The InContext Web Site

Document Summaries

November 2007

In Context

Creating the balance in the nursing curriculum

Case summaries for the majority of the case files contained on the InContext web site are listed below. You can locate files via the website by searching using the case file number, entered without spaces.

Some of the files found will have tutor comments and prompts attached that suggest how the particular case entry might be used in a teaching and learning context. These files are indentified by (with comments) in parenthesis located to the right of the case file number.

Profile of Adult Patient Case 00-002

Document summary

No admission notes. Unclear why or where from admission took place.
Diagnosed as suffering from a carcinoma of the lung confirmed as being an undifferentiated small cell carcinoma from biopsies taken at the time of bronchoscopy.
Nursing care issues predominantly relate to care of the terminally ill patient and palliation.
Marked weight loss associated with nausea a key case feature.
Patient ultimately discharged to care of District Nurse, McMillan nurse and GP.

Profile of Adult Patient Case 00-004

Document summary

71 year old male admitted via outpatients with Shortness of Breath and diagnosed as exacerbation of Asthma. Known asthmatic, three previous admissions for flare up of his asthma.
Treatment included 02 therapy a range of bronchodilators, steroids and antibiotics. Sputum incubated Haemophilus parainfluenza. Allergic reaction to Singulair resulted in quite marked Angio Oedema.
Nursing care input focused on management of the marked and prolonged breathlessness and its impact on his ability to self care. Gradually improved over the course of his eighteen day admission and was discharged care of GP.

Profile of Adult Patient Case 00-008

Document summary

Acute emergency admission via A&E. History of chest pain and fluttering sensation in the chest. Assumed to be a myocardial Infarction but this was discounted on ECG tracings and negative Trop I blood tests.
Main complaint of liquid diarrhoea associated with severe stomach cramps/spasms. Recently underwent Heller's Myotomy for oesophageal stricture requiring further surgical revision for dysphagia. Caught Norwalk Virus following surgery.
The diarrhoea is intractable with only short periods of relief with Octreotide medication, but leading to constipation, withdrawal and return of symptoms. A battery of tests including barium studies, pancreolauryl test, microbiological studies all fail to demonstrate aetiology for the diarrhoea. One suggestion is that the diarrhoea is attributable to vagus nerve damage during surgery for his oesophageal stricture.
Known sufferer of Rheumatoid Arthritis with associated mobility problems requiring him to use a Zimmer Frame.
Patient discharged without a firm diagnosis or explanation for the diarrhoea. Sense of the patient is 'fed up' and low and wants discharge with or without resolution for his diarrhoea.

Profile of Adult Patient Case 00-009

Document summary

Patient admitted as an acute emergency admission with Increasing SOB for 2 weeks.
Now finding it difficult to get around house; Cough; No sputum SOB at rest; PND a; Orthopnoea a; Ankle swelling for last 7 days, diagnosis Left Ventricular Heart Failure (LVF)
Treated with diuretics and Digoxin.

Profile of Adult Patient Case 00-013

Document summary

Acute admission via doctors deputising service with history of Right Upper Quadrant and epigastric pain associated with vomiting.
History of previous surgery for Intussusceptions as a child and bowel resection fifteen years ago. Examinations, including ultrasound were unremarkable. Managed conservatively with Intravenous Infusion and sips of clear fluids plus analgesia.
Patient made a spontaneous recovery and was discharged on day three. At follow up she was asymptomatic and discharged ROD.

Profile of Adult Patient Case 00-014

Document summary

Acute admission with intermittent severe abdominal pain associated with nausea and vomiting.
Previous extended right hemicolectomy and splenectomy; partial pancreatectomy. For Dukes B colonic adenocarcinoma. Treated conservatively nil by mouth and intravenous infusion.
CT scan reported a Inflammatory mass, antereomedial abscess, left psoas.
Pain settled down quickly and was she was discharged home on day three.

Profile of Adult Patient Case 00-015

Document summary

Acute admission with history of severe upper abdominal pain associated with nausea and vomiting. Already scheduled for waiting list laparoscopic Cholecystectomy in three days time.
Settles quickly on conservative management, Nil by Mouth, Intravenous Infusion and proceeds to surgery as planned.
Uneventful Post-operative recovery and discharged on day seven with follow up in six weeks.
Note from transcriber. Nursing notes not available.

Profile of Adult Patient Case 00-017

Document summary

List case admission for repair anterior posterior vaginal repair.
Surgery performed repair of Cystocoele + Rectocele. Made a relatively good post – operative recovery complicated by problems passing urine when the catheter was removed. Residual urine determined by ultrasound scan measured 839 ml confirmed as 900ml at re-catheterisation. Patient was 'desperate' to be discharged with or without the catheter and it was agreed to discharge with catheter in situ to return in one week for further trial without catheter.

Profile of Adult Patient Case 00-018

Document summary

List case admission for vaginal hysterectomy because of irregular menses, pain and dyspareunia; young at thirty nine for this procedure.
Surgery performed Vaginal Hysterectomy with pelvic floor repair. Large uterus but no operative complications. Post operatively complained of pain in both right and left iliac fossa and periumbilical. Developed a low grade pyrexia the aetiology of which was never fully explained, treated with Augmentin.

Catheterised for the operative procedure catheter removed on day six only twenty five ml of residual urine measured on post micturition scan. Urine noted to have blood ++ protein ++ Mid Stream Urine specimen (MSU) sent to lab for culture and sensitivity (C&S).
Discharged on day seven to continue antibiotics.

Profile of Adult Patient Case 00-019

Document summary

Thirty-nine year lady admitted for total abdominal hysterectomy because of menorrhagia and uterine fibroid.
Uneventful intra - operative period. Developed severe abdominal pain post parandial on post operative day three queried to be paralytic ileus or obstruction. Settled down on nil by mouth and IV fluids. Catheter removed on day four scan showed 250 ml residual urine but no intervention ordered. Discharged on day seven.

Profile of Adult Patient Case 00-020

Document summary

List case admission for vaginal posterior repair for prolapse. At time of operation large rectocele identified, no enterocele, small cystocele.

Constipated post-operatively treated with oral laxatives, suppositories and enemata (phosphate, Microlax). Catheterised for the operative procedure removed on day four but catheter had to be reinserted because of urinary retention. Catheter removed on day six with no evidence of urinary retention on ultrasound scan (25 ml residual).
Discharged on day eight; returned to the ward on day ten complaining of vaginal and perineal pain reassured and prescribed Sultrin cream. Swab taken for Culture & Sensitivity was reported as showing no significant growth.

Profile of Adult Patient Case 00-023

Document summary
Eighteen year old male, elective admission with hyperthyroidism, for Thyroidectomy.
Noticed weight loss three months ago and associated palpitations. Visited GP who diagnosed Thyrotoxicosis (Grave's). Started on Carbimazole – initially good response.
Last 2-3/52 – feels tired/weak.
No palpitations; ↑ tremor;
Heat intolerance ++; No double vision;
No discomfort; No grittiness. Sore throat settled now.
Weight ↑ by approximately 2 stone since two months.
No real improvement or response to Rx therefore admission for surgery.
Swallowing poor -difficult with solids. 'Bread' feels stuck ½ way down. Large goitre and thyroid bruit noted.
Underwent total Thyroidectomy. Uneventful poet operative recovery with no signs of tetany, Chvostek's sign negative, Trousseau's sign negative; no hoarseness. Felt his strength was returning, noted abdominal and chest acne developed post operatively.

Profile of Adult Patient Case 00-024

Document summary
List case admission for Aorta Bifemoral Bypass.
He suffers from Claudication pain bilaterally at ten yards for the past twelve months or more; stopped smoking one year ago.
Had a routine stay in High Dependency Unit (HDU) immediately post op and then transferred back to the surgical unit for further recovery and rehabilitation.

Post recovery complicated by groin and abdomen wound haematomas that ultimately caused the wounds to become necrotic requiring mechanical and chemical debridement with Eusol and Paraffin.
Finally discharged on day forty four on antibiotics and care of the district nurse for continued management of the wound break down.

Profile of Adult Patient Case 00-026

Document summary

Acute emergency admission via AE. Presenting Complaint: woken from sleep – 02.00hrs with burning central chest pain radiating into throat. Similar pain yesterday, burning. Settled sufficiently with Gaviscon to allow sleep. Also describes similar problems previously.
Known sufferer from Ischemic Heart Disease, Angina and had previous suffered a Myocardial Infarction (MI).
Fully investigated for MI including series of Electrocardiograms (ECG) that showed no new changes. Diagnosed as oesophagitis or gastritis and treated conservatively with Antacids.
Discharged on day eight.

Profile of Adult Patient Case 00-028

Document summary

Acute admission with history of sudden onset of Shortness of Breath (SOB) about 1½ hours ago; dull ache in chest before breathlessness. No nausea / vomiting / sweating. Has had admissions in the past for 'water round the heart.'
Diagnosed as Left Ventricular Failure (LVF) and cardiac dysrhythmia. Treated with diuretics and settled quite quickly. Echocardiogram showed moderate LVF.
Threatened to sue NA because he developed a large haematoma on the dorsum of his hand following removal of a Venflon. Patient became very upset about this and told the N.A to "cover herself because his solicitor was going to hear about this". The doctor saw the patient and explained that the haematoma formation was unfortunate but occasionally happened. When asked about his concerns he said that it looked awful and would take months to go away. He was worried about what people would think had happened to him in hospital and that he would be left with a black hand forever. No indication of how this resolved.
Discharged home on Day 11 on Ramipril 2.5 mg to be increased to 5mg over the next three to four weeks.

Profile of Adult Patient Case 00-031

Document summary

Acute admission with left sided weakness and drooping on left side of face, slurring of words. Diagnosed as hypertension and left hemiparesis.
CT scan of the brain revealed infarct in the thalamus region, carotid artery Doppler detected no abnormalities (NAD).
Patient made steady progress with the left sided weakness resolving. Fully assessed by Occupational Therapy staff for transfer capabilities, bed to chair, toilet etc, dressing and washing and kitchen skills. Fully independent in all activities of daily living (ADL).
Discharged home on day eleven with anti hypertensive medication (ACE inhibitor).

Profile of Adult Patient Case 00-033

Document summary

Fifty-eight year old lady acute admission. Chest pain for past 2 hours compressing type of pain, radiating to shoulders and jaw; associated with sweating and nausea. History of palpitations no history of SOB / cough with expectoration / fever.

She is a known patient with lateral wall ischemia diagnosed by Thallium scan two weeks ago and hypertension. ECG on arrival; at A&E showed some heart block and ectopics (unfortunately ECG not available to the study). No evidence of an myocardial infarct, symptoms thought to be attributable to underlying Ischemic Heart Disease
Treated conservatively and discharged home on day seven with follow up in cardiology clinic.

Profile of Adult Patient Case 00-039

Document summary

71 year old male - Elective admission for sigmoid colectomy. Sigmoidoscopy revealed large sessile polyp; Metaplastic / hyperplastic polyp; No dysplasia/malignancy. Histological examination of the resected sigmoid colon reported Diverticular disease including diverticular abscess.
Did well early post operative period but then developed a swollen right on day eight. No evidence of cellulitis and a good pedal pulse led the medical staff to investigate for Deep Vein Thrombosis (DVT). Patient underwent Doppler Venogram Right Lower Limb: that was reported as no evidence of DVT. Around this time developed a wound swelling that was thought to be possibly a haematoma or fluid collection but the wound remained intact.
Became acutely short of breath on day fifteen, chest X-Rays at the time suggested pleural effusions in both lung bases and she was treated as chest infection Augmentin prescribed.
Apart form some wound pain investigated by Ultrasound Scan she made steady and good progress and was discharged home on day twenty-four.

Profile of Adult Patient Case 00-041

Document summary

Thirty year old Female admitted for laparoscopic Cholecystectomy.
Post operative recovery complicated by internal bleeding and urinary retention. The internal bleed resolved itself without any need for operative intervention. Haemoglobin levels fell sufficient to require blood transfusion with two units of whole blood and Fe medication. It is not clear from the medical or nursing record what explained the urinary retention. Treated with urinary catheterisation the urinary retention apparently resolved in twenty-four hours.
Discharged home on day six.

Profile of Adult Patient Case 00-044

Document summary

Acute admission with Right Iliac Fossa pain (RIF). Sudden onset RIF pain constant dull ache; intermittent sharp pain; Pain increases when laying flat; vomited coffee ground; nauseated occasionally. Diagnosed with acute appendicitis.
Appendecectomy performed moderately inflamed appendix found, terminal ileum caecum normal. Uneventful post operative recovery. Home on antibiotics.

Profile of Adult Patient Case 00-046

Document summary

Acute admission with intermittent Right Upper Quadrant pain (RUQ) for past four days increasingly severe on day of admission. Pain associated with bilious vomiting that relieved the symptoms. Pain radiates to the back and she has been shivering ? Rigors.
Has had Ultrasound Scan (USS) recently that reported a Gall Bladder (GB) full of calculi and a soft tissue mass within Common Bile Duct thought very unlikely to be a tumour.
Symptoms settled on conservative treatment including antibiotics. Underwent uneventful open Cholecystectomy on day sixteen. Uneventful post operative recovery apart from one episode of fluid overload causing oedema (requiring rings to be removed) treated with diuretics.

Histology of the gall bladder reported an adenocarcinoma completely enclosed and therefore excised with the gall bladder. Discharged circa day twenty-five.

Profile of Adult Patient Case 00-047

Case summary

Admitted from clinic. Three month history of intermittent burning/crushing epigastric pain. One episode of bilious vomiting and diarrhoea, several weeks of severe itching. Ten day history of increasing jaundice, dark urine, pale stools.
A battery of tests and investigations are performed to establish the aetiology for the jaundice. Ultrasound Scan is reported as normal particularly with no biliary obstruction. Liver biopsy is performed and reported as ….cholestasis and focal lobular inflammation. Extrahepatic (large duct) obstruction and a drug reaction should be considered in the first instance.
Discharged home on day twenty-two with no definitive diagnosis and for follow up in clinic.

Profile of Adult Patient Case 00-050

Case summary

Booked Admission for Right Radical Nephrectomy.
Previous history of Deep Vein Thrombosis (DVT) currently taking anti-coagulants, Warfarin tablets. Made an uneventful post operative recovery, catheter removed on day ten.
Histological examination of the excised kidney reported a tumour …The tumour is a conventional clear cell renal cell carcinoma (Fuhrman grade 2). The tumour is confined to the kidney and no further evidence of sarcomatoid change or vascular invasion is seen. No lymph nodes are identified.
Summary: Right kidney renal cell carcinoma.

Profile of Adult Patient Case 00-051

Case summary

Seventy-year old man, elective admission. Admitted for right Nephrectomy due to carcinoma of the kidney, and incisional hernia repair. Right hemicolectomy two years ago for Ca bowel. Known to suffer from Atrial Fibrillation, treated with Digoxin and Warfarin.
Developed hypotension associated with oliguria in the immediate post operative period, challenged with IV fluids, plasma expanders and blood transfusion. Urine output improved following Frusemide administration. Reported to have bilateral lung creps
Nursing care aimed at general postoperative care for the surgical patient [including wound drain management], care of the urinary catheterised patient, and management of pain using Patient Controlled Analgesia [PCA], blood transfusion/IV fluid maintenance.
No indication from nursing or medical entries if the diagnosis and/or prognosis were discussed with the patient or his relatives.
Discharged from hospital on day twelve, clips removed from a healthy wound. Follow up for INR blood test and referred to haematologist for further management of his Warfarin therapy.

Profile of Adult Patient Case 00-052

Case summary

Fifty-eight year old lady admitted for Hysterectomy and anterior repair. The reason for the hysterectomy is not explicit in the medical notes or nursing notes.
Mother died from pulmonary embolism and both of her two sisters were blood tested positive for factor V Leiden. In view of the history innohep and the fitting of TED stockings were prescribed. Uneventful postoperative recovery. Nursing care related to general pre & postoperative nursing care including care of the urinary catheter, IV infusion, peritoneal drain and pain management. Discharged on day six on innohep and TED stockings for follow up as an outpatient.

Profile of Adult Patient Case 00-053

Case summary
Thirty two year old female admitted for bilateral ovarian cystectomy.
Discharged without any procedure on first admission because of a sore throat treated with penicillin. Re-admitted six weeks later and underwent surgery.
Uneventful postoperative recovery apart from some urinary retention that required urinary catheterisation. Nursing care relating to general pre & post operative nursing care.
Discharged on day five.

Profile of Adult Patient Case 00-054

Case summary
Forty-five year old female admitted for Total Abdominal Hysterectomy [TAH]. Long time sufferer with Dysmenorrhoea and Menorrhagia, inter uterine fibroid noted on examination.
Developed a fever and pyrexia post operatively attributable to a wound infection with staphylococcus and streptococcus. Treated with antibiotics and made a full recovery.
Otherwise an uneventful post-operative recovery.
Nursing care relating to general pre and post operative management including management of Intra Venous fluids, indwelling urinary catheter, patient controlled analgesia, wound drain and general wound care.
Discharged home on Antibiotics on day ten post operative.

Profile of Adult Patient Case 00-055

Case summary
Seventy-two year old male admitted to 'AMU' (assume Acute Medical Unit) from outpatients clinic for investigations of increasing shortness of breath and chest pain, subsequently transferred to a medical ward. Ex-smoker (stopped 12 years ago). Has lost 2 stone in weight over last 2 months on a diet (weighs 16stones 10lb [106kg])
Fully investigated including radiological investigations conducted: Chest X-ray CT abdomen CXR shows large left pleural effusion & cardiomegaly some radiological evidence of a cardiac tamponade but no supporting clinical evidence. Possible malignancy of the heart considered and discussed with the patients relative but discounted on subsequent radiological evidence [MRI] that reported a resolving picture.
Generally improved over the duration of his in-patient stay with his shortness of breath resolving. Twenty-two day stay in hospital.

Profile of Adult Patient Case 00-058

Case summary
73-year-old retired male
Planned admission for femoral popliteal bypass surgery
History of claudication in left leg when walks less than 50 yards. Same in right leg when walks 100 yards.
Previous medical history: Cerebra Vascular Accident (CVA) 1 year ago, multiple Transient Ischemic Attacks (TIAs)
Smoker (5-6 per day)
Femoral Popliteal bypass surgery performed under general anaesthetic. Post operative Doppler examinations demonstrated a patent well functioning graft.
Nursing management related to general pre and post operative care including care of wound suction drains, pain management, Intravenous fluid management, and mobilisation.

Profile of Adult Patient Case 00-059

Case summary
Fifty-seven -year-old male
Planned admission for parathyroidectomy
Previous medical history: Removal of pituitary adenoma in 1995 resulted in panhypopituitarism. Entered into a research study [growth hormone depletion] and found coincidentally to be hypercalcaemic. Non-smoker, occasional alcohol, occupation: Engineering instructor.
Developed tingling in his hands and face and a positive Chvostek's sign suggested hypocalcaemia [tetany] confirmed by a low blood Ca 2+ .Hypocalcaemia treated by oral calcium. Nursing care related to care of the pre/postoperative patient including management of IV fluids, pain management and management of the suction drain.
Discharged on day five for early follow up.

Profile of Adult Patient Case 00-062

Case summary
Thirty-one year old Female admitted with abdominal pain left upper quadrant. Known to have Gall Stones and is currently on the waiting list for cholecystectomy. Recent episode of Pancreatitis caused by a migrating gall stone, recent miscarriage. On admission Serum Pancreatic Amylase raised confirming the diagnosis of Pancreatitis which was treated conservatively with IV Fluids and Nil By Mouth [NBM]. Ultrasound demonstrated a distended Common Bile Duct [CBD], gall stones and 'sludge' in the Gall Bladder.
Recovered quickly from her Pancreatatic episode and went to have laparoscopic cholecystectomy during the current admission from which she made an uneventful postoperative recovery, discharged home on day thirteen.

Nursing management related to care of the patient with an acute abdomen including IV fluid replacement, monitoring of pain, NBM management, general pre and postoperative care.

Profile of Adult Patient Case 00-065

Case summary

Eighty-year old male admitted with chest pain and acute shortness of breath (SOB). Known to suffer from angina but pain leading up to admission was the worse ever with no relief. ECG on admission suggested an arteroseptal myocardial infarct [MI] confirmed by follow up ECG's. Thrombolysed with streptokinase. Developed some disorientation and left sided weakness following thrombolysis that may have been a consequence of his MI or due to treatment [iatrogenic]. Some discussion with his family in the early stages of his treatment regarding resuscitation options, the prognosis was described as 'guarded' by the medical team. Son agreed to resuscitation and non invasive ventilation but did not think that his father would want Intensive Care Support including mechanical ventilation.

Chest X-Rays and chest auscultation both confirmed pulmonary oedema treated with high doses of diuretics in the first instance tipping the patient into dehydration requiring gentle rehydration with intravenous Infusions of Normal Saline. Despite his guarded prognosis he went on to make a good recovery and was discharged home on day eleven following his admission.

Nursing management related to intensive systemic monitoring and support in the early admission period to advise on cardiac rehabilitation prior to discharge. Good evidence of family support and communication throughout the inpatient stay.

Profile of Adult Patient Case 00-080

Case summary

Forty-eight year old female emergency admission via GP with increasing shortness of breath [SOB]. Known chronic chest necessitating frequent admissions for treatment last admission four weeks ago. Cigarette smoker for the past thirty-five years admits to still smoking five cigarettes per day, adamant she will quit smoking this time.

Blood gases were taken frequently and reported raised pCO2 reduced pO2 with associated acidosis. SOB treated with O2 and bronchodilators and she gradually improved over the course of her admission and was discharged on day fourteen.

Nursing management related to care of the breathless patient including O2 therapy and monitoring of arterial blood gases. No record in the nursing notes that advice on smoking cessation techniques were discussed with the patient despite her declared intention and resolve to quit smoking 'this time'.

Profile of Adult Patient Case 00-081

Case summary

Thirty-four year old female admitted via GP with 'flare up' of eczema. Current episode started three weeks ago with rash to her arms, trunk and legs. Treated by her GP with oral steroids and Flucloxacillin. Rash began to clear but one week ago widespread pustular lesions developed over body, face and scalp. Diagnosed in hospital as Chicken Pox treated with topical emulsifying creams and oils and antibiotics. Responded well to treatments. Noted to be anaemic; this was attributed to her reported Menorrhagia. Anaemia treated with iron supplements.

Nursing management related to observation and monitoring of the rash and treatment with IV antibiotics and topical application of various creams. Discharged on day eight following review by dermatologist.

Interestingly, the patient herself did not think the rash was a flare up of her eczema as it felt different to previous flare ups particularly as there was no associated itching.

Profile of Adult Patient Case 00-082

Case summary

Eighty-two year old male admitted with acute Shortness of Breath (SOB). Referral letter from AMU read:

This gentleman is complaining of dyspnoea on exertion, sometimes he gets breathless even just sitting down, for the last few days it has worsened. He has no chest pain. There is slight pitting oedema in both legs, BP 130/80 HR 68/mt, chest bilateral diminished air entry.

He suffered from hypertension for many years. He has severe osteoarthritis affecting multiple joints and spine and he has Gout. ECG revealed RBBB and LBBB. I am a bit concerned sending him home though his symptoms are not severe. I would be grateful for your opinion.

Formal diagnosis not recorded but ECG changes and congestion noted.

Nursing management primarily aimed at observation and management of his SOB and monitoring response to treatments.

Profile of Adult Patient Case 00-083

Case summary

Eighty-four year old male ex-miner; acute admission with chest pain, fine all day then went up to bed and felt cold. Went to get a blanket and had chest pain – lasted twenty minutes. Known to suffer from Angina Pectoris and recently developed Diabetes Mellitus [type 2] controlled with diet and oral hypoglycaemic medication. ECG tracings on admission show right bundle branch block and left anterior hemi block but no evidence of acute Myocardial Infarction. Final impression was that the symptoms were due to infective state query viral infection.

Made an unremarkable recovery, discharged home on day four reporting that he was back "to best."

Nursing management related to observation and monitoring of treatment regimes, including O2 therapy and nebulisers therapy, management of the breathlessness and monitoring of his Diabetes Mellitus.

Profile of Adult Patient Case 00-093

Case summary

Eighty-five year old male emergency admission via GP presenting with absolute constipation for the past four days. Diagnosed as a bowel obstruction secondary to adhesions [previous Appendecectomy] CT scan of the abdomen demonstrated/confirmed a small bowel obstruction.

Treated conservatively and his abdominal symptoms settled down quickly. passing flatus and tolerating free fluids by day 4. Developed acute retention of urine that required urinary catheterisation, known to have Prostatism. Trial without catheter unsuccessful requiring re-insertion.

Nursing management related to monitoring and observation of treatment regimes, care of the patient: when nil by mouth, with intravenous infusion in situ, with urinary catheter in situ.

Discharged home on day eighteen care of GP and social services. For readmission in six weeks for further trial without catheter.

Profile of Adult Patient Case 00-094

Case summary

Eighty year old female admitted via GP with a twenty-four history of intermittent right sided abdominal pain associated with low grade pyrexia. Ultrasound scan demonstrated a gall stone.

Treated conservatively with nil by mouth, Intravenous Fluids, Intravenous Antibiotics.

Responded well to treatment and quickly progressed to diet and fluid intake. Developed itchy skin, the aetiology of which was not determined, treated with Piriton.

Nursing management related to observation and monitoring of treatment regimes, care of the patient who is nil by mouth and having Intravenous fluid replacement.

Discharged home on day six care of daughter with social services and dietician referrals.

Profile of Adult Patient Case 00-095

Case summary

Twenty-three year old female. Acute admission via emergency doctor with history of abdominal pain localised in the right iliac fossa. Diagnosed as acute appendicitis and treated by Appendecectomy.

Nursing management related to observation and monitoring of treatment regimes, care of the pre and post operative patient including intravenous fluid replacement and intravenous antibiotics. Settled quickly following surgery and was discharged home on day four.

Profile of Adult Patient Case 01-001

Case summary

Fifty eight year old female admitted as an emergency with severe abdominal pain in the Right Upper Quadrant radiating to her back associated with nausea. Known to suffer from ME and usually feels unwell.

Diagnosed as an acute Cholecystitis. Ultrasound scan demonstrated a solitary gall stone impacted in the gall bladder neck. Reported has having a high body mass index and the patients weight was recorded [on the TPR Chart] as 87.2kg but no height measurement is recorded.

Medical treatment consisted of intravenous Anti Biotic therapy, pain relief. She made an uneventful recovery apart from one episode of chest tightness treated with Salbutamol. Discharged on day seven with follow up cholecystectomy in the near future. Nursing care related to monitoring of response to treatments, management of pain, management of Intravenous infusion.

Profile of Adult Patient Case 01-002

Case summary

Seventy-four year old female elective admission for sub-total Gastrectomy. Endoscopy revealed prominent antral lesion and biopsies at the time showed abnormal cells histological examination reported high grade dysplasia. CT scan one prior to admission reported no intra abdominal spread of gastric lesions. There was no overt evidence of carcinoma but in view of the histology the MDT felt it appropriate to recommend sub-total gastrectomy.

A D2 sub-total gastrectomy was performed was performed on day two of the admission and the patient was recovered in ICU for twenty four hours prior to transfer back to the surgical ward. Medically the patient made an uneventful post operative recovery. Seen by dietician on three occasions regarding advice on meals content and portion size, recommended small nutritious meals regularly.

Nursing care related to monitoring of condition and general post operative nursing care including: care of the catheterised patient, care of the patient with Naso Gastric tube, care of the patient with IV fluid replacement, care of the wound, diet control and monitoring.

Patient made an uneventful all round recovery and was discharged home on day seventeen following admission care of district nurse and GP.

Profile of Adult Patient Case 01-003

Case summary

Sixty-one year old female acute admission with pyrexia, rigors, nausea and a discharging wound. Diagnosed as having developed enterocutaneous fistulae.

Recently discharged from the surgical ward after having had a reversal of Hartmann's procedure and two further laparotomies to a leak at the anastomosis site. What is confusing is that the patient still has a colostomy.

Treated conservatively with antibiotics, restricted fluids and low residue diet in the first instance, later TPN via long line. The fistulae failed to close spontaneously leading to surgical intervention to formalise the enterocutaneous tract followed later by laparotomy and direct closure. Post operatively the wound broke down and was discharging faecal fluid. Faecal fluid oozing via the wound was thought to be secondary to constipation and this was treated with enemata via the stoma leading to some improvement in the amount of faecal discharge. Nursing management was complex and required input from stoma therapists, tissue viability nurses and pain specialists. Discharges from the wound and fistulae were very caustic to the surrounding skin leading to marked excoriation and pain caused by a rawness of the skin. Dehiscence of the wound complicated the management of the discharging fistulae through application of protective flanges and stoma bags as it was difficult to maintain adherence to the skin leading to frequent failure of the seal and fistula discharge onto the skin.
Not surprisingly, the patient became very low and depressed at the protracted progress towards recovery. However, she did eventually make a recovery with the wound intact and apparently healed. She was discharged seventy-seven days after admission to the care of district nurse for daily dressings.

Profile of Adult Patient Case 01-004

Case summary
Sixty-four year old female acute admission with abdominal pain that originally thought to be non Specific Abdominal pain [NSAP]. Abdominal X-Ray demonstrated free air under the hemi-diaphragm that confirmed the diagnosis of perforated Duodenal Ulcer. Taken to operating theatre for overseeing of the ulcer. Medical plan included: Urinary catheter passed to monitor urinary output, IV fluids + antibiotics, Naso Gastric Tube [NGT] and Nil By Mouth [NBM]. Cared for in the immediate post operative period in High Dependency Unit [HDU]. Nursing care/management related to support for a patient undergoing abdominal surgery, monitoring of vital signs including urine output, management of the patient with intravenous infusion, management of the surgical wound. The patient had some mobility problems on the ward that were managed by the use of a Zimmer frame and later with walking sticks for post discharge. Evidence of input from several health care professionals including Occupational Therapy [Ot], Medical Social Worker [MSW], Physiotherapy and Dietician.
Made an uneventful post operative recovery and was discharged home on day twelve.

Profile of Adult Patient Case 01-005

Case summary
Sixty-eight year old female admitted via A&E with history of acute, severe abdominal pain. Complex medical past history including total right and partial left Nephrectomy for Ca, metastatic papillary thyroid Ca, Colectomy, Cholecystectomy, Hysterectomy known Angina and COPD sufferer.
A raised serum Amylase of 1026 confirmed the primary diagnosis of Pancreatitis [reported by the admitting doctor as being secondary to alcohol] chest infection and anaemia [Hb 7.8] also

noted [diagnosed]. Medical plan included Nil By Mouth [NBM] IV fluids, IV antibiotics, urinary catheterisation, steroids and analgesia.
Ultrasound and CAT scan both reported a retroperitoneal mass probably inflammatory arising from the pancreas.
Nursing management included care of the acutely ill patient, monitoring of urine output, monitoring blood glucose levels. Care of the patient undergoing oxygen therapy [nebulisers], IV therapy including IV antibiotics and blood transfusion. Evidence of family support.
Patient made a good recovery and was discharged on day twelve for follow up in outpatients and repeat CT scan of abdomen in two weeks.

Profile of Adult Patient Case 01-006

Case summary

Thirty-nine year old man admitted as an emergency via A&E with severe abdominal pain. The patient was discharged from hospital recently [two days prior to this admission] following an episode of severe epigastric pain similar to the pain causing this admission. Admitting doctor's impression was gastritis or pancreatitis with a significant functional overlay.
Steadily at first and then more rapidly he deteriorated over a three-day period confused, disorientated, sweating. Taken to theatre for a laparotomy where he was found to have an infracted small bowel, which was resected. Unfortunately 10 days after his first operation he developed an anastomotic leak requiring a second laparotomy. He spent a long time ventilated and breathing spontaneously on the intensive Care Unit. The underlying cause for the intestinal infarction was never fully determined although it was highly suspicious that this was due to some form of thrombophilia. He was therefore, anti-coagulated.
The surgeon notes in his discharge letter: "At all times he made massive efforts to help himself to get better and I believe that he may not have survived if he had not exhibited such strength of character"…… "He is truly a remarkable man."
Nursing care relates to the management of the patient in pain, monitoring and recording vital signs and responses to treatments, catheterised patient and intravenous infusion. Records of care from ICU are missing.
Patient was discharged approx fourteen weeks following admission on Warfarin and for follow up CT scan as an outpatient.

Profile of Adult Patient Case 01-007

Case summary

This patient is a fifty-seven year old gentleman who was admitted into hospital via the Accident and Emergency Department with abdominal pain and distension. His previous history consisted of an Illeostomy for Ulcerative Colitis and Insulin Dependent Diabetes Mellitus (IDDM).

On admission into hospital he was found to have a reduced output to the stoma and a reduced urine output. He was also unable to tolerate diet and fluids due to vomiting. He was reported to have some weight loss over a period of several months.

He was initially treated with Intravenous (IV) fluids and medication. A naso-gastric tube was inserted due to vomiting and a urinary catheter was inserted. Whilst in hospital various investigations and procedures were undertaken which included a Laparotomy and small bowel resection and anastomosis.

Post operatively he developed a chest infection and was transferred to a High Dependency Unit for intensive monitoring and the insertion of an arterial line. His condition stabilised and he was transferred back to the ward twenty-four hours later.

The nursing management for this patient includes a referral to the Dietician, Physiotherapist, Tissue Viability Nurse, Social Worker and Diabetic Specialist Nurse.

His condition gradually improved and he was discharged to his sister's address after forty-four days in hospital.

Profile of Adult Patient Case 01-008

Case summary

Thirty-nine year old male admitted as an emergency via A&E with a one-day history of sudden onset of abdominal pain [thirty minutes after taking food] associated with vomiting. Diagnosed as biliary colic confirmed by ultrasonic evidence of presence of gallstones in a tender gall bladder.

Treated conservatively by nil by mouth, intravenous infusion and intravenous antibiotics.

Nursing management related to care and management of the patient: in acute pain, acute emergency admission, nil orally, Intravenous infusion and antibiotics, fluid balance monitoring.

Patient made an unremarkable recovery and was discharged on day five with follow up appointment and referral for laparoscopic cholecystectomy.

Profile of Adult Patient Case 01-010

Case summary

Medical History: Acute Admission via A&E with severe abdominal pain. Diagnosed as suffering from Acute Pancreatitis diagnosis confirmed by a raised serum amylase of 3040 U/L (range 25 –125). Pancreatitis secondary to gallstone migration confirmed by ultrasound. Managed conservatively Nil orally and Intravenous Infusion Fluids, Catheterised. Insulin Sliding Scale prescribed Known to suffer from Diabetes Mellitus controlled by diet

Past history of anterior resection of rectum for Ca Colon – Illeostomy formed but reversed.
Two Incisional hernia one arising from anterior resection and second from? Illeostomy site.
Discharged on day nine for with referral for open cholecystectomy.
Nursing Needs Identified as relating to:
An acute admission, information giving for patient and family, communication on plans.
Management of pain including assessment, evaluation, and recording reviewing analgesia
Care of the urinary indwelling catheter, prevention of ascending infection, accurate monitoring of volume and nature of urine output including and recording same.
Care of the diabetic patient including monitoring of blood sugars, administering sliding scale, education and general support for the patient.
Care of the fasting patient to include mouth care, management of fluid replacement by Intravenous infusion, and equipment cannula, line etc.
General care including hygiene needs and other activities of living.

Profile of Adult Patient Case 01-011

Case summary

This is a ninety-one year old lady who was admitted with lower back pain.
She had a fall three weeks prior to this admission when she sustained an injury to her lower back. She was originally treated by her GP for back pain with analgesia which she was unable to tolerate due to nausea.
The past medical history for this patient is Osteoarthritis. Prior to this admission into hospital, this lady was fully independent and she lives alone. She is normally quite active and enjoys painting and exhibits her paintings at local art shows. In addition to the injury to her lower back resulting from the fall, there was also evidence that she had sustained a burn to her lower back from a hot water bottle. She was initially treated with analgesia and it was planned that she would be transferred to another hospital for rehabilitation, although this was delayed as there was an out break of diarrhoea and vomiting on the rehabilitation ward where she was scheduled to be transferred to.
Her condition improved whilst on the ward awaiting transfer and she requested to go home. She was seen by the Discharge Coordinator who reported that she was known to the social services department and therefore did not need to be referred. The lady's daughter agreed to support her at home over the bank holiday period until home support could be commenced, she was therefore discharged home after sixteen days in hospital.

Profile of Adult Patient Case 01-012

Case summary

Seventy-six year old man, known with severe COPD, was admitted as an emergency with an infective exacerbation. He was producing increasing amounts of purulent green sputum and had some associated left sided chest pain. Chest X ray on examination showed previous asbestos related changes, but no new abnormality. Arterial blood gases on 24% oxygen showed a pO2 of 9.6 and pCO2 of 4.72 (he is normally on a long term oxygen therapy at 2litres/minute) Sputum grew Serratia Marcescens, which was sensitive to Ciprofloxacin and Gentamicin, but resistant to Amoxycillin, Coamoxiclav and Cefuroxime.

He was treated with Levofloxacin, nebulised bronchodilators, oral steroids, oxygen and intravenous Aminophylline and made a slow but steady improvement. He was troubled by an episode of sinus tachycardia, thought to be precipitated by his Aminophylline and his dose of Salbutamol was temporarily reduced. His peak flow on discharge was 210litres/minute. He will be followed up at his existing appointment in two months.
Nursing management related to monitoring of treatment regimes and observations. Nursing management included Oxygen therapy, collection and safe disposal of body fluids [sputum]. Discharged on day seventeen.

Profile of Adult Patient Case 01-013

Case summary
Eighty-year old Female - A&E referred. Known Hypertension on Atenolol 50mg OD for 2-3yrs. Recent episode of diarrhoea four weeks back, seen by GP for loose stools yesterday started on Dicyclomine 20mg OD. Had breakfast had Dicyclomine and Atenolol, felt dizzy. Collapsed, loc – 30's – 1 minute. Came around in few minutes. No recall of events. No C/o headache, chest pains, slurred speech. Paramedics found her to be Bradycardiac had 500mcg of Atropine. Impression collapse? Cardiac Arrhythmia - side effect from of medications?
Made an unremarkable recovery. Atenolol discontinued and commenced on Bendrofluazide for her hypertension. Diagnosis collapse with side effect of medication being the favoured explanation. Nursing management related to acute admission, monitoring of treatment regimes and observations.

Profile of Adult Patient Case 01-014

Case summary
Seventy-six year old female found collapsed at home. Known hypertensive treated with Losartan 50mg, took double her normal dose of Losartan yesterday by mistake. Not feeling well since yesterday dizzy and finding it difficult to find her words in normal conversation. Paramedics noted a Glasgow Coma Scale score of 8 and BM of 6.5, patient was sweaty. Had a thirty second self terminating clonic type seizure in the ambulance. The doctors Initial diagnosis was stroke and haemorrhage with ride sided hemiparesis; this was revised to include probable aspiration pneumonia. Noted to be Hyponatraemic - cause?
Treatment commenced included Intravenous fluids + nil orally, IV antibiotics, insertion of urinary catheter reason for catheterisation not stated. Made an unremarkable recovery her Hyponatraemia thought to be secondary to her pneumonia.
Nursing care for this patient related to care of the unconscious patient, observations including neurological, monitoring of the Intravenous fluids, management of the indwelling urinary catheter, pressure area care, communication with the son & daughter on the seriousness of their mothers condition.
Other professionals involved with the patients care included Speech & language Therapist and Physiotherapy.
The lady progressed well and was well enough to sit out of bed by day three. IV and catheter were removed on day four and the lady was discharged to her home with family support on day five following admission.

Profile of Adult Patient Case 01-015

Case summary

Seventy six year old female, admitted to the ward via Accident and Emergency Department with a history of collapse and loss of consciousness. This patient had suffered with similar episodes of collapsing over a period of three months prior to admission. Found on the floor by her friend, where she had been for several hours throughout the night. Reported to have had a poor appetite for 6 weeks prior to admission associated with weight loss and reduced mobility.

Past medical history included Hypertension, Type 2 Diabetes Mellitus, and Hypothyroidism. This patient also had a stoma, and had a diabetic ulcer to her right leg. Prior to this admission into hospital, she lived alone in a bungalow with the District Nurses regularly attending to dress the leg ulcer and to check her blood glucose levels. The patient was awaiting Lava treatment to the leg ulcer although the Primary Care Trust could not fund this. Whilst in hospital she developed multiple complications and it is unclear what caused the complications. Having been initially diagnosed with fast Atrial Fibrillation and Postural Hypotension, for which she was treated with medication and discontinued from some of her normal medication. Throughout the period of her stay she was found to be having episodes of fast Atrial Fibrillation with episodes of Ventricular Tachycardia. Abnormal blood results indicated impaired renal function that again was treated with medication. Episodes of haematuria and blood clots were also reported and it was believed that this was due to a urine infection for which she was treated with antibiotics. Further investigations revealed stones in the urinary tract. Whilst in hospital, the patient complained of having difficulty when swallowing and had several episodes of nausea. Although an Endoscopy was arranged this procedure was not performed. Nursing management included input from the dietician, the coordinator for the elderly, tissue viability nurses and diabetic nurses.

Unfortunately this lady's condition deteriorated throughout the period of hospitalisation. Following multiple medical complications she was diagnosed with metabolic acidosis and septic shock, the prognosis was poor. Discussions were held with the doctors and the patient's family in relation to her prognosis. A decision was made that the patient should not be resuscitated or ventilated in the event of Cardiac Arrest. The family requested that the patient be made comfortable.

The patient's condition continued to deteriorate despite treatment and she died peacefully following a forty-day stay in hospital. May she rest in peace.

Profile of Adult Patient Case 01-016

Case summary

Acute admission with central "crushing" type chest pains and shortness of breath. Patient was discharged from hospital on the previous day to this admission following treatment for intermittent chest pains. Chest pains worse on exertion.

Diagnosed with unstable angina, cholesterol noted to be raised. Treated with medication, investigations were undertaken and she was commenced on a heart monitor. The patient

had several episodes of chest pain whilst on the ward. On day 8 the patient reported that she 'felt out of sorts', he was seen by doctor who thought it was indigestion, she was known to have reflux oesophagitis. The patient was found to be in complete heart block on Day 12. Following insertion of a urinary catheter, she was transferred to the Coronary Care Unit for close monitoring. Seven days later it was agreed by the medical staff that the patient required a Permanent Pacemaker. The patient was consented and the pacemaker was successfully inserted. Seen by the physiotherapist on several occasions in the days following the procedure, patient was assessed on walking up the stairs. She managed this assessment although she became short of breath, despite her observations being stable. The patient requested that her bed at home be moved downstairs as she did not want to walk upstairs. Discharged home on day 26.

Profile of Adult Patient Case 01-017

Case summary

This eighty-three year old lady was admitted via her GP with a history of falls and a reduced appetite. Known to have Osteoarthritis to her right hip, she also has a history of breast cancer, Chronic Obstructive Pulmonary Disease (COPD), Cor Pulmonale and Hypertension. She was admitted into hospital as she was unable to manage at home.

This lady was previously assessed for a left hip replacement although this was not performed as she had some other problems at the time. Reviewed by the Orthopaedic surgeon on the ward and agrees to the operation despite the risks involved. However there are some concerns expressed by the consultant in relation to her chronic chest condition. Following an assessment by the anaesthetist a decision is taken that she is not fit to undergo surgery due to her chronic chest condition. She is later referred to the Pain clinic to be assessed for pain relief. The nursing management of this patient consists of a referral to the Occupational Therapist, Physiotherapist and Social Worker. This lady is discharged home following a twenty day stay in hospital with home support.

Profile of Adult Patient Case 01-018

Case summary

This male patient was admitted following a domiciliary visit by the consultant. The patient was unable to walk for three weeks prior to admission. He had a poor appetite and had recently developed constipation. The patient also complained of having shakes to his hands and 'flickery' eyes, he also had difficulty in swallowing. The GP had organised for the patient to have a wheelchair. Previous history of Polyneuropathy. The patient was unable to manage at home and was admitted into hospital for further investigations.

Initially diagnosed with polymotorneuropathy, it was also considered whether the symptoms may be a result of a stroke or a space occupying lesion in the brain. After a short length of time in hospital the patient requested to change consultant and this was accepted. Various investigations were performed, findings from an Endoscopy revealed lesions in the oesophagus. Nursing management of the patient included Speech and Language assessment, physiotherapy, dietician and occupational therapist.

Initially treated with Intravenous Fluids and Nil by Mouth due to swallowing difficulties, the patient was later treated with Naso Gastric feeding. This was removed when the condition improved and diet was tolerated. The patient was transferred to a rehabilitation ward where his condition continued to improve, he was gradually able to mobilise short distances with a walking aids and foot supports.
Following a 28 day stay in hospital the patient and his wife requested that he be discharged home, although they were satisfied with his care they felt that he would improve within his home environment with support from the community rehabilitation team. Although the nursing staff advised that the patient remain in hospital for further rehabilitation, the patient insisted that he wanted to go home. The patient was discharged home with a care package in place.

Profile of Adult Patient Case 01-019

Case summary
This patient is a 96 year old gentleman who was admitted via his GP after being found collapsed at home by his daughter, unable to weight bear. He is known to have angina, hypothyroidism and heart failure. He also has a colostomy in place due to a history of bowel cancer six years ago. He is initially treated for Left Ventricular Failure (LVF) and Cardiomegaly.
Following several episodes of haematuria, he is treated with antibiotics for a possible urinary tract infection. Following the acute phase, he is later transferred to another hospital for rehabilitation. The nursing management for this patient includes referral to the Physiotherapist, Occupational Therapist and Social Worker. Whilst in hospital he develops a swelling in his right leg which is treated as a potential Deep Vein Thrombosis (DVT). A decision is made that the patient should not be for resuscitation in the event of Cardio Pulmonary Arrest. Following further investigations, there is no apparent DVT of the leg and following a period of rehabilitation, the patient is discharged home after 28 days.

Profile of Adult Patient Case 01-020

Case summary
Acute admission with sudden onset of chest and abdominal pain. The past medical history for this patient is complex, including a history of Alcoholic Liver disease, Congestive Cardiac Failure (CCF), Aortic valve disease, Coronary Artery Bypass Graft (CABG), Type 2 Diabetes Mellitus and leg ulcers. Initially diagnosed with Oesophageal spasm but to rule out the possibility of a Myocardial Infarction (MI).
Treated for Hyperkalaemia with oral medication and intravenous fluids. Whilst in hospital was seen by the dermatologist due to leg ulcers. This patient had various investigations performed including an Endoscopy and abdominal Ultrasound. The ultrasound revealed gall stones and an enlarged liver. There are some references made to his mood being low whilst in hospital, it is unclear whether or not any treatment was given for this. Discharged home on day 18.

Profile of Adult Patient Case 01-021

Case summary

This is an eighty-nine year old lady who was admitted via her GP with increasing dyspnoea and a cough for 3 weeks; she had a recent hospital admission prior to this admission with left sided abdominal pain to which no cause was found. Having completed two courses of antibiotics prescribed by her GP her condition was not improved.

This patient is an ex smoker, she lives alone in a bungalow and her family help to assist her. There is a query in relation to whether this lady has had Tuberculosis in the past. There are reports that she had been previously diagnosed with asthma although no treatment was given. Diagnosed with severe exacerbation of asthma, and treated with steroids and bronchodilators. Nursing management for this patient included a referral to the Occupational therapist, Physiotherapist and Social Worker. This lady was treated as an inpatient for 10 days until she was discharged home.

Profile of Adult Patient Case 01-022

Case summary

This forty-one year old gentleman was an elective admission via the Out-Patients Dermatology Clinic with severe exacerbation of eczema mainly affecting his right thigh and buttocks. This patient has a life long history of dermatitis; he is unemployed and lives alone. His previous history also includes an above knee amputation to his right leg. He was unable to apply his prosthesis due to his skin being affected by eczema, which therefore affected his mobility. Known to be allergic to Penicillin and reported to be sensitive to dairy products, which exacerbated his condition. During his stay in hospital he was tested for specific allergies. His treatment consisted of the application of various ointments, lotions and the use of specific bath oils to reduce the condition. This patient was in hospital for a total of seven days during which his condition gradually improved and he was discharged home with the District Nurses visiting twice weekly. A follow up appointment was arranged for him to attend the Dermatology clinic 6 weeks later.

Profile of Adult Patient Case 01-023

Case summary

This eighty one year old lady was admitted via her GP with a history of increasing dyspnoea on exertion and hypertension. Known to have a history of Hypertension, Congestive Cardiac Failure, Asthma and Iron Deficiency Anaemia. This lady had been unwell for two weeks prior to admission with abdominal pain, diarrhoea and a reduced appetite. Initially diagnosed with acute renal failure, secondary to dehydration and medication she was later discovered to have a raised white cell count and was commenced on Intravenous (IV) fluids and antibiotics. Whilst in hospital this lady developed a widespread rash to which the cause was unknown it was questioned whether this was a reaction to some medication. The diarrhoea settled and the lady was diagnosed with sepsis. Her condition improved whilst in hospital and her symptoms resolved, she was discharged to her home address after a six day stay in hospital.

Profile of Adult Patient Case 01-024

Case summary

This patient is a seventy-two year old lady admitted with increasing shortness of breath and diarrhoea. She had been discharged from hospital 4 weeks prior to this admission after being treated for exacerbation of Chronic Obstructive Pulmonary Disease (COPD). Her medical history includes COPD and angina. Following an initial diagnosis of infective exacerbation of COPD, suspected infected diarrhoea and oral candidosis, she was treated with Intravenous (IV) fluids, IV antibiotics and oxygen. A diagnosis of pneumonia was confirmed. The nursing management of this lady includes referral to the Occupational Therapist. There are some concerns raised by the Occupational Therapist in relation to whether this lady was being discharged on home oxygen although it would appear that she is not.

Within the documentation there is also evidence of a disagreement between the patient and a nurse following the patient adjusting the oxygen when she felt breathless.

This lady was discharged home after seventeen days in hospital.

Profile of Adult Patient Case 01-025

Case summary

This seventy-three year old lady was admitted into hospital with a one week history of headaches, nausea, weakness to her legs and numbness to the right side of her face. She had recently (within the six months prior to this admission) been treated for B-Cell lymphoma for which she had received chemotherapy and radiotherapy treatment, and the lymphoma was reported to be in remission. There is a detailed list from the GP with the details of previous medical history. She had previously attended the Accident and Emergency department 3 days prior to this admission and was treated with antibiotics and anti- emetics. On admission she was unable to walk due to weakness in her legs and had been 'dragging' herself around at home with her husbands help. It was questioned whether this lady may have a brain lesion and a CT scan was performed which was found to be negative. An MRI scan later unveiled a tumour to the brain stem which was initially believed to be due to lymphoma, the patient was informed of the results of the scan and commenced on medication. The lady was referred to the neuro-surgeon and it was felt that the lesion was not due to lymphoma but due to an infarct to the brain stem.

The patient improved whilst in hospital, she was referred and seen by a dietician due to raised cholesterol. After a total of seventeen days in hospital she was discharged home without the need for any additional support.

Profile of Adult Patient Case 01-026

Case summary

This 83 year old lady was admitted via her GP following a history of weight loss, she was extremely low in energy and unable to get out of bed due to fatigue. She had previously been

diagnosed with iron deficiency anaemia which responded well to treatment, although she had declined further investigations. On admission into hospital she appeared quite confused and was diagnosed with sepsis secondary to a urinary tract infection. A chest x-ray also revealed some shadowing there was some consideration whether this was a mass; however she was initially diagnosed and treated for pneumonia.
Blood results revealed that the liver function tests were elevated; the medical staff suspected that the lady had metastatic bronchial carcinoma and a bronchoscopy was performed. Within the notes it was documented that this lady should not be for resuscitation in the event of cardio respiratory arrest. However, the bronchoscopy and abdominal ultrasound investigations did not detect any abnormal masses. The patient was discharged home after 7 days.

Profile of Adult Patient Case 01-027

Case summary
This gentleman was admitted via his GP after waking one morning to find that he had a weakness to his left arm and left leg. He has a previous history of Chronic Obstructive Pulmonary Disease (COPD). The patient is the main carer for his wife who is known to have Alzheimer's disease. Initial diagnosis was that he had suffered from a stroke. Although his mobility was affected and he had some facial drooping, he was able to swallow and within 5 days following admission, he was able to dress himself. After being informed that he was able to go home the patient expressed his concern about this, he felt that he wouldn't be able to cope at home with his wife. He was later referred to the Occupational Therapist. Following a period of rehabilitation, his condition improved. Communications were held between the Occupational Therapist and the Community Social worker to arrange his discharge home and arrangements for his wife so that they will be supported once he is discharged home. The patient was discharged home after a 14 day stay in hospital.

Profile of Adult Patient Case 01-028

Case summary
This 87 year old female was admitted into hospital via her GP with a history of vomiting overnight and increased shortness of breath. According to the patient she has 2 episodes of 'blood stained' vomiting throughout the night. This lady lives alone and is independent for most activities of daily living. She has a previous medical history of Iron deficiency anaemia, congestive cardiac failure, Myelodysplasia. Treated one year ago for 'coughing blood' and pneumonia. No evidence of malaena whilst in hospital, no change to her haemoglobin level. Although she was found to be pyrexial on admission, treated for a urinary tract infection (UTI) and discharged home following a 3 day stay in hospital.

Profile of Adult Patient Case 01-029

Case summary

Admitted with a history of centralised chest pain radiating to both arms and back, used her GTN spray with good effect. History of angina for several years - also had triple by-pass surgery nine years ago. This lady is a 79 year old ex-smoker; she lives alone and is normally very active and independent. Her angina is well controlled following the coronary artery bypass grafts until 2 weeks prior to admission when she has had frequent episodes of chest pain. Diagnosed with unstable angina, although further episodes of chest pain mislead the diagnosis of cardiac chest pain or epigastric chest pain as this patient is also known to have a hiatus hernia.

Throughout her stay in hospital, various investigations were undertaken and she was treated with medication for angina. There is also evidence that she was visited by the Elderly Care Co-ordinator who noted that the patient wanted to go home and that she was disappointed after being advised to stay in hospital due to recurrent episodes of chest pain. This lady was discharged home after an 11 day stay in hospital with an Echocardiogram test to be arranged as an Out-Patient.

Profile of Adult Patient Case 01-030

Case summary

Admitted via the Accident and Emergency department with a two week history of excessive vomiting and abdominal pain. Reported to also have a two month history of weight loss

This lady is normally chair bound at home and lives with her husband who is her full time carer. Her previous medical history is complex and includes Crohn's Disease, Illeostomy, Type 2 Diabetes Mellitus, Cholecystectomy, Congestive Cardiac Failure, Ischemic Heart Disease and Pernicious Anaemia. Initially diagnosed with acute renal failure, Endoscopy procedure performed which appeared to be normal. Some amendments made to medication. Condition appeared to resolve and she was discharged home after a seven day stay in hospital.

Profile of Adult Patient Case 01-031

Case summary

This patient is a seventy-nine year old lady admitted via the Accident and Emergency Department with palpitations and left sided chest pain whilst playing bowls. Her previous medical history includes Hypertension and Ischemic Heart Disease. This lady lives at home with her husband; she is normally active and independent. Whilst being examined by the doctor she lost consciousness for a brief period of time which resolved. An Electrocardiogram was performed which revealed fast Atrial Fibrillation for which she was treated with medication. Investigations were undertaken to rule out a Myocardial Infarction which proved to be negative.

After responding well to treatment, she was discharged home following a four day stay in hospital; a follow up appointment was arranged for her to attend the Out-Patients Department two weeks after discharge.

Profile of Adult Patient Case 01-032

Case summary

This eighty-three year old gentleman was admitted via the Accident and Emergency department following one episode of vomiting 'coffee ground' vomit. He was also reported to have a reduced appetite and weight loss in recent weeks. His past medical history consisted of Hypertension and he is allergic to Penicillin. He was initially treated with Intravenous (IV) antibiotics and IV fluids following a diagnosis of pneumonia. After four days as an in-patient he had no episodes of vomiting and as his condition improved he was able to tolerate diet and fluids. During his stay in hospital he was also found to be incontinent of urine which was noted to be a long standing problem. The nursing management for this patient included a referral to the Occupational Therapist for assessment as he is the main carer for his wife. In addition, he was referred to the District Nurses prior to discharge. There is some evidence that concerns were raised by his daughter regarding his planned discharge as she felt that her father was breathless, although it is noted by the doctors that he did not appear to be breathless. Therefore he was discharged home following a nine day stay in hospital. Arrangements were made for him to return for a follow-up appointment in the Out-Patients Department and a bladder scan was arranged to investigate the reasons for his urinary incontinence.

Profile of Adult Patient Case 01-033

Case summary

This sixty year old gentleman was admitted via his GP with reduced mobility, increasing dyspnoea and diarrhoea. This patient is known to have Parkinson's disease for which he takes medication. Two days prior to this admission he was discharged from hospital but was unable to cope at home despite having home care visits three times per day.
Whilst in hospital on the previous admission he was found to have Clostridium Difficile for which he was treated. On admission into hospital he appears confused, he does not understand what medication he takes and why. He also has a sacral sore. Initially, he is treated with medication for the chest infection and diarrhoea. His past medical history
The nursing management for this patient includes a referral to the Parkinson's Nurse and referral to the Social Work department to be assessed for Residential Care. Although medically well, he is unable to be discharged until arrangements are made for him to be suitably accommodated. The case goes to a panel which is delayed and results in a prolonged discharge. Following the case going to panel, he is eventually discharged to a Residential Home following a forty-four day stay in hospital.

Profile of Adult Patient Case 01-034

Case summary

This patient is an eighty-three year old gentleman, admitted to the ward via his GP with a history of vomiting and rigors, symptoms that were initially suspected to be due to a urinary tract infection (UTI). This patient had attended the Accident and Emergency department on the day prior to admission and was discharged home with antibiotic treatment for a UTI. Following deterioration in his condition he was admitted into hospital. Further investigations revealed a diagnosis of pneumonia for which he was treated with intravenous antibiotics. Previous medical history included, Myocardial Infarction, Cerebro vascular accident, Parkinson's disease, Osteoarthritis and a hiatus hernia. There is evidence within the nursing notes that the patient complains that his chair is uncomfortable and asks for the nurse in charge. The patient's daughter asks for an apology for the way that her father was spoken to by one of the nurses; the nurse assures the daughter that this will be resolved although it is unclear whether this happened.

The patient's daughter also reported to staff that her father had some episodes of diarrhoea whilst in hospital and it was suspected that this was a result of the antibiotic therapy. In conclusion the patient responded well to his treatment and was discharged home after a ten-day stay in hospital without the need for any services to be implemented.

Profile of Adult Patient Case 01-035

Case summary

This patient is a seventy-nine year old man who was admitted to the ward via the Accident and Emergency department with a two-day history of diarrhoea and vomiting. Past medical history includes Hypertension, Ischemic Heart Disease and Peripheral Vascular disease. He was treated for renal impairment, which was caused by gastroenteritis. He was treated with Intravenous fluids and after a four day stay in hospital was discharged home.

Profile of Adult Patient Case 01-036

Case summary

This seventy–eight year old gentleman was admitted via his GP with a history of dizziness and generalised weakness. He has a previous medical history of Ischemic Heart Disease and has had a Cerebral Vascular Accident (CVA) in the past. No previous history of Diabetes although on admission his blood glucose was found to be elevated and treatment was initiated for this. He was found to have a drop in his blood pressure on standing and it was believed that this was due to his medication, this was amended and support stockings were provided to wear. The nursing management for this patient includes a referral to the Diabetic Specialist Nurse, Physiotherapist, Dietician and District Nurses. There is some evidence that the patient's daughter expressed concerns regarding his discharge, as she felt that his wife would not manage with him at home. However, despite this concern being raised it would appear that his discharge proceeded and he was discharged home after a total of sixteen days in hospital with the district nurses attending to monitor his blood glucose levels.

Profile of Adult Patient Case 01-037

Case summary

This ninety- seven year old gentleman was admitted via the Accident and Emergency Department with epigastric and abdominal pain. His previous medical history includes Ischemic Heart Disease, Atrial Fibrillation, Hiatus Hernia and Pernicious Anaemia. There is some question in relation to whether or not he also has an Aortic Aneurysm, although this has not been confirmed in the past. For the past eighteen months he has required oxygen therapy at home. He is known to live alone with some support with meals and cleaning.
Whilst in hospital various investigations were undertaken, his blood results indicated some renal impairment although it was noted that although abnormal the results were similar to previous results. However, an ultrasound scan of his abdomen confirmed an Aortic Aneurysm, following discussions between the medical staff and the patient regarding the risks and benefits of the surgery to repair the aneurysm the patient decided not to have the surgery. His pain settled whilst he was in hospital and he was discharged home after nine days in hospital.

Profile of Adult Patient Case 01-038

Case summary

This seventy-eight year old lady was admitted via her GP with a sudden onset of dyspnoea and fainting episodes. Five weeks prior to this admission into hospital, she had sustained a fractured neck of femur to her right leg, for which she was treated with surgery. Since the surgery she was mobilizing well with a frame, although she had recently been treated with compression stockings by her GP due to a swollen leg. Her previous medical history includes Myocardial Infarction, Ovarian Cystectomy, Hypertension, Anaemia and Osteoporosis.
On admission she was initially diagnosed with Atrial Fibrillation, and it was later confirmed that she also had a Pulmonary Embolism (PE) and Pneumonia, for which she was treated with medication.
Whilst in hospital she had several short episodes of ‘black outs’ where she became unresponsive. After a prolonged period of stay in hospital her condition deteriorated, she developed cardiac failure and renal failure and her diagnosis was poor. It was therefore agreed that she should not be resuscitated in the event of cardiac arrest. Despite her condition, she requested to be discharged home with support, therefore arrangements were made for her to have oxygen therapy organised for her discharge and a home visit was planned.
However, her condition deteriorated further despite treatment, she collapsed and later died in hospital after a total of fifty-three days. Rest in Peace.

Profile of Adult Patient Case 01-039

Case summary

This eighty-one year old lady was admitted via the Accident and Emergency department with a history of fainting at home, and was observed to have lost consciousness. She was reported to have had similar episodes of fainting prior to this. On admission, there was no

history of chest pains or palpitations; she was under awaiting an Endoscopy examination as an Outpatient due to nausea. Initial treatment consisted of Intravenous fluids, which were later discontinued.
Various investigations were undertaken on admission and an Electro Cardiogram (ECG) recording revealed Atrial Fibrillation. However, further ECG's were reported to be 'normal'. A further 24-hour ECG recording was also found to be within normal limits.
Following a negative screen for a Myocardial Infarction the lady was discharged after a three-day stay in hospital as an inpatient.

Profile of Adult Patient Case 01-040

Case summary
This patient is an eighty-six year old gentleman who was admitted into hospital via his GP with a two-week history of a rash and bilateral swelling to his legs. His previous medical history includes two Cerebro-Vascular Accidents (CVA's) and one convulsion several years ago. He is not known to have any skin conditions apart from Rosacea in the past. He is also known to have Atrial Fibrillation (AF) and Ischemic Heart Disease.
Following his admission he is referred and assessed by the dermatologist and further investigations of the rash are performed. These include a skin biopsy to determine the cause of the rash. Various treatments are prescribed and administered for the rash.
On the same day of admission, an Electrocardiogram (ECG) investigation revealed that he was in complete heart block; he was therefore transferred to the Coronary Care Unit for further observations and monitoring. Having been monitored within the Coronary Care Unit and found to be having episodes of heart block, a decision is made for him to have a permanent pacemaker inserted. This procedure is performed successfully and he is later transferred back to a ward.
Following further reviews and treatment by the dermatologist the rash appears to be gradually improving.

Profile of Adult Patient Case 01-041

Case summary
This is a complicated case of a lady who was originally admitted into hospital with a history of diarrhoea and abdominal pain, unable to cope at home. Her past medical history included Gout, Parkinson's disease and Diverticulitis. In admission into hospital she was initially diagnosed with Gastro-enteritis and monitored for signs of sepsis. The diarrhoea persisted whilst she was on the ward, and a urinary catheter was inserted to monitor the hourly urine output. Blood samples were taken daily for Urea and Electrolyte levels. She was treated with Intravenous fluids and antibiotics. An Echocardiogram was performed which indicated abnormalities, these were discussed with the patient and the option of surgery to improve the cardiac function was offered, the patient agreed that she would consider this.
Although the diarrhoea settled after several days, she began to feel nauseous and the blood results indicated deterioration in the renal functions. She was then treated with Intravenous fluids and anti-emetics. An abdominal x-ray was performed and the possibility of a bowel obstruction was ruled out. The nursing management included a referral to the dietician due to

poor appetite, nausea and weight loss. The lady began to develop oedema and was treated with diuretics. Stool cultures proved to be negative for infection, therefore a flexible Sigmoidoscopy investigation was performed which did not reveal any specific abnormalities. A CT scan of the abdomen was then arranged to explore the possibility of diverticular abscess. The patient then began to pass diarrhoea and had several episodes of vomiting. A rash was noted to both shins, the cause of which appeared to be unknown. Following deterioration in the patient's condition, she was given diamorphine to settle her. However this was later discontinued due to a drop in her blood pressure and a reduced early warning score.
After 24 days in hospital the patient's condition began to deteriorate rapidly and the Vasculitic rash to the legs became widespread, the diagnosis remained unknown. In light of the lady's poor prognosis it was decided that she should not be resuscitated in the event of cardiac arrest and this was discussed with her daughter. It was explained to her daughter that although there was no clear diagnosis it was likely to be renal failure secondary to diarrhoea and vasculitis. The family were in agreement with the decision regarding resuscitation.
The patient's condition continued to deteriorate rapidly following this discussion and she died after 26 days in hospital. Rest in peace.

Profile of Adult Patient Case 01-042

Case summary

This seventy-three year old gentleman was transferred from another hospital after being in hospital for twelve days with pain and swelling to his left shoulder. He was diagnosed and treated for septic arthritis of his shoulder joint with an arthroscopic washout. Although this had resulted in some improvement to his symptoms, he then developed severe back pain and weakness with altered sensations to his legs. An urgent MRI scan revealed discitis with vertebral osteomyelitis. A spinal biopsy was performed which was negative, although the shoulder aspirate grew Staph Aureus for which he was treated with antibiotics.
Throughout the period of treatment, he regained some power in his legs and his blood results indicated an improvement in his condition. He spent a prolonged period of time on bed rest and was eventually able to sit out of bed as his condition improved. A diagnosis of Chronic Osteomyelitis was confirmed.
The nursing management for this patient included a referral to the Physiotherapist and a referral to the Occupational Therapist.
As his condition improved he was able to mobilise with assistance and with the use of a walking frame. After a prolonged period of seventy-three days in hospital it was arranged for the gentleman to go home for weekend leave, however he failed to return to hospital after the weekend visit and he was therefore officially discharged on day seventy-six.

Profile of Adult Patient Case 01-044

Case summary

This fifty-year old lady was an elective admission for conversion of a right Halifax nail to a total right hip replacement for the treatment of Osteoarthritis.

Her previous medical history includes alcoholic liver disease, partial Gastrectomy, Appendecectomy and Hysterectomy.
During the operation the Halifax nail was found to be infected and was removed. The conversion to a total hip replacement was therefore delayed until a later stage. The lady was treated for the infection with intravenous antibiotics via a central catheter, which was later removed due to the patient developing pyrexia. A conversion operation was subsequently undertaken to replace the right hip joint.
The nursing management for this patient includes a referral to the Physiotherapist.
This patient was discharged home following a seventy-four day stay in hospital with an Out-Patient follow up appointment for three months time.

Profile of Adult Patient Case 01-045

Case summary
This fifty-eight year old gentleman was admitted into hospital as an elective admission for a right Total Hip Replacement. His previous medical history includes a Coronary Artery Bypass Graft (CABG), Hypertension and two Hernia Repairs. The surgical procedure is performed as planned, however two days later the patient is found to be pyrexial. Although investigations were undertaken to determine the cause of the pyrexia the outcome of the cause of the pyrexia remains unclear. However, the gentleman gradually begins to mobilise independently as his mobility improves.
The nursing management for this patient includes referrals to the Physiotherapist, Pain Nurse and the District Nurse.
This gentleman is successfully discharged home following a total of seven days in hospital.

Profile of Adult Patient Case 01-046

Case summary
This sixty nine year old lady was an elective admission for a right total knee replacement. She was admitted to the ward after being assessed in the Pre Op clinic. Her previous medical history included a left total knee replacement, hypertension, hypothyroidism, Appendecectomy, hysterectomy, mirodiscectomy, and a thyroidectomy.
The operation was performed successfully and the patient began to mobilise soon after the surgery. There is some concern several days post operatively that there is swelling to the operated knee area although this later appears to be improving.
The nursing management for this patient includes a referral to the Pain Nurse, Physiotherapist and the District nurses.
This lady was discharged home following a period of nine days in hospital.

Profile of Adult Patient Case 01-047

Case summary

This sixty-year old lady was an elective admission for a right Total Knee Replacement.
Her previous medical history consists of Hysterectomy, Appendecectomy, Tonsillectomy and a fractured wrist.
The operation was performed and the patient's mobility improved throughout her stay in hospital. There is some concern regarding her leg being swollen several days post operatively however an ultrasound scan was performed which was reported to be normal.
The nursing management for this patient includes referral to the Pain Nurse, District Nurse and Physiotherapist.
This lady was discharged home on day 13.

Profile of Adult Patient Case 01-049

Case summary

This seventy-nine year old lady was admitted into hospital following a fall at home whilst gardening. She sustained a fracture to the right neck of femur and required surgery.
Her previous medical history includes angina and hypertension. She also had previous surgery for a right total knee replacement and a cholecystectomy.
An operation was performed to pin the joint, however the patient later developed Methicillin-Resistant Staphylococcus Aureus (MRSA) in the wound, which prolonged her treatment.
The nursing management for this lady included a referral to the Occupational Therapist, District Nurse and Physiotherapist.
Throughout her stay in hospital her condition gradually improved and she was discharged home after eighteen days.

Profile of Adult Patient Case 01-050

Case summary

72 Year old female admitted to the orthopaedic ward via A&E with dislocation of right hip. Past history of bilateral hip replacement twelve years ago. Previously three episodes of the hip 'feeling like it was coming out' but not clear if the hip actually dislocated or not. This time when arising from sitting on a chair the hip dislocated, painful with shortening of the right leg. Hip manipulated under anaesthesia easily reduced but noted to be unstable in adduction, flexion & internal rotation also loose on longitudinal traction. Patient informed that she will require further arthroplasty to stabilise the hip joint. Evidence of multi agency involvement in discharge planning and preparation. The patient is not confident that she will be able to cope with caring for herself after discharge and refuses to be discharged when deemed to be suitable for discharge. Discharged home on day twelve care of a friend.

Profile of Adult Patient Case 01-051

Case summary

Eighty –seven year old lady admitted with dislocation of right hip. Total hip replacement six years ago since then one other episode of hip dislocation three months prior top this admission. The lady spent all night laid on the floor at home in severe pain could not get herself up to standing. On admission, in pain over hip area with any movement, right leg externally rotated. X-ray confirmed posterior dislocation of the hip. Dislocation reduced by Manipulation under Anaesthesia. Uneventful post operative recovery. Gently mobilised with Zimmer frame and nursing assistance to gain confidence discharged home on Day four. Placed on waiting list for Augmentation of right hip.

Profile of Adult Patient Case 01-052

Case summary

Thirty-one year old male admitted to the orthopaedic ward via A&E with history of a severe fracture of his right Talus sustained in a Road Traffic Accident [RTA]. Fracture reduced and fixed with screw and K-wires under general anaesthesia. Developed acute retention of urine post-operatively [confirmed by bladder scan – 850ml residual urine] for which he was catheterised. Catheter was removed on the third day and the patient passed urine without difficulty. Some worries expressed by the patient regarding potential complications, osteonecrosis, arthritis etc. Mobilised on crutches non weight bearing and was discharged home on day eight.

Profile of Adult Patient Case 01-053

Case summary

Eighty-two year old lady admitted to Medical Assessment Unit [MAU] with history of pain on eating and difficulty in swallowing, queried pulmonary aspiration. Initially managed by Intravenous Infusion [IVI], Nil By Mouth [NBM] and the passing of a Naso Gastric Tube [NGT] to decompress/aspirate the stomach.

Had a right Cerebral Vascular Accident [CVA] three years ago that left her with a left sided hemiplegia. Several extensions to her CVA since initial, resulting in moderate dysphagia. Speech and Language Therapist [SALT] has been advising on management of the patient's dysphagia and the Dietician advising on diet including dietary supplements.

Transferred to the rehabilitation unit for monitoring and rehabilitation including mobilisation and diet. Noted to have a pressure sores on her left heel and left external malleolus. Pressure sores managed by mechanical and chemical debridement and various dressings recommended for the management of malodorous wounds. Occasional urinary incontinence particularly nocturnal diurnally appears to be continent.

Ability to mobilise severely affected by her hemiplegia requiring the aid of a Zimmer frame plus person to mobilise and two people for transfers. The team recommend discharge to a care home as she deemed unsuitable for discharge to her home as she would no be able to manage self care. Initially reluctant to agree to the care home suggestion preferring instead to

be discharged home. Ultimately, agrees to be discharged to a local nursing home and is discharged on day seventy-six.

Profile of Adult Patient Case 01-057

Case summary

This seventy-six year old gentleman was admitted to the ward via his GP, the GP reported that the patient needed further investigations for spinal problems and lower back pain. However on admission, the main problem appeared to be his reduced mobility due to a loss of balance. He was admitted following a fall where he had banged his head and lost consciousness for approximately ten minutes.

His previous medical history includes Chronic Renal Failure, Hypertension, Myocardial Infarction, Hypercholesterolaemia and Peripheral Vascular Disease. He attends the hospital for Haemodialysis three times per week.

Whilst in hospital various investigations were undertaken to determine the cause of the abdominal pain, including an Abdominal Ultrasound scan. He was later diagnosed and treated with antibiotics for a urine infection. There is some comment in relation to the patient having Parkinson's disease although there doesn't appear to be any confirmation of this diagnosis. Whilst in hospital, he was found to have a necrotic toe and there is also evidence to suggest that he had Methicillin-Resistant Staphylococcus Aureus (MRSA).

This gentleman lives alone and although it is apparent that he wishes to go into a Residential home he requests to initially be discharged to his home address so that he can sell his house.

The nursing management for this gentleman includes referrals to the Occupational Therapist, Social Worker, Physiotherapist, Infection Control Nurse and Podiatrist.

Following an assessment by the Social Worker, it is felt that he does not require full time care although provisions are made for him to continue to receive 'Meals on Wheels' as he was prior to the admission.

On the day of discharge there is some evidence that he refuses to take the medication, however the discharge goes ahead and he is discharged home after a period of twenty-four days in hospital.

Profile of Adult Patient Case 01-058

Case summary

This seventy-six year old gentleman was admitted from the Anti Coagulant Out-Patient's clinic with a three day history of Haematuria. He has a previous medical history of Prostrate Carcinoma, a Deep Vein Thrombosis (DVT) several years ago to the right leg and was diagnosed with a DVT six weeks prior to this admission, also to the right leg. He had a resistance to Warfarin and was therefore taking Phenindione.

During his stay in hospital the Haematuria stopped and he was reviewed by an Urologist. It was suggested that the Haematuria was secondary to the anti coagulant therapy. A Kidney and Bladder Ultrasound was arranged to rule out the possibility of any obstruction.

The nursing management for this patient included a referral to the dietician due to raised cholesterol levels.

His condition improved and he was discharged home after a total of fifteen days in hospital.

Profile of Adult Patient Case 01-059

Case summary

This eighty-four year old gentleman was admitted via the Accident and Emergency department with a history of chest pain and dyspnoea. His past medical history included Epilepsy and Hypertension.

Various investigations were performed which revealed that he was Anaemic for which he was treated with a blood transfusion. He was provisionally diagnosed with a Gastro Intestinal (GI) bleed however an Endoscopy investigation proved to be normal. He was also treated for and Congestive Cardiac Failure (CCF) with medication.

A full blood count (FBC) post transfusion was found to be within the normal limits and he was later discharged to his home address following an eleven-day stay in hospital. A follow up appointment was arranged for him to have a Barium Enema investigation as an Out Patient.

Profile of Adult Patient Case 01-060

Case summary

This eighty three year old gentleman was admitted to the ward via his GP with a history of passing dark stools and had several episodes of shaking or 'rigors'. His past medical history includes Arthritis, Atrial Fibrillation (AF), a Myocardial Infarction and Urinary frequency. He is on various medications including warfarin.

On admission, he is found to have bilateral pitting oedema to his feet for which he is treated with medication. Various investigations were undertaken during his stay in hospital and it is suspected that he has had a Gastro intestinal bleed for which an Endoscopy procedure is planned; however this was later deemed not to be necessary. Following some amendments being made to the patient's medication throughout the period of his stay, his condition improved.

The nursing management for this patient includes a referral to the Occupational therapist and the Physiotherapist and communications with the Continence Nurse.

Following a seven-day stay in hospital the patient was discharged to his home address with home care. An appointment is made for him to attend the Anti-Coagulant clinic.

Profile of Adult Patient Case 01-063

Case summary

This sixty six year old lady was admitted as an elective admission to the Ear Nose and Throat (ENT) department for a Right Labyrinthectomy. She had a three-month history of dizziness and deafness with transient facial palsy for which she was being treated with Stemetil.

The surgical procedure was performed and post operatively she was treated with Stemetil and Intravenous antibiotics. She initially required some assistance with mobility due to being unsteady when walking. However she successfully recovered during the postoperative

period. The nursing management for this lady included a referral to the physiotherapist. The initial planned discharge date was delayed as it was felt that she would not manage at home. However, as her condition improved, she was discharged following a nine-day stay in hospital. An Out Patient appointment was arranged for two weeks later.

Profile of Learning Disability Case 01-091

Case summary

The client is a 19 year old lady with moderate learning difficulties. She was a school pupil until she reached the age of 16, from which she had attended college on a full time basis. Twelve months ago she resided at a private residential home for people with learning difficulties aged between 18/41 years in this area. Previously, she was admitted to a children's centre for a long placement four and a half years ago due to a breakdown in the relationship between her and her mother. Fifteen months ago she was admitted to the Mental Health Unit under Section 2 of the MHA following a period of very unstable and extremely challenging behaviours towards her mother and staff at the resource unit.

She has a violent relationship with her mother and most of her challenging behaviours are directed towards her. Her mother also has a mild learning difficulty. She is an older carer with mobility problems and other health needs. When Rose was living at home with her, her mother found it arduous to cope with her daughter's behaviour, her understanding of rules and boundaries are a concept that her mother has trouble managing with and this has consistently been the situation since she was a small child.

She is known to target male support staff with provocative behaviour/ challenging behaviour and to take the hand of male service user and rubbing it on her private areas. Deemed to be at risk from sexual/ financial/ physical/ psychological abuse. Possible risk of exploitation from males in the community.

The story concludes with doing really well both at the hospital and at her visits home.

Profile of Learning Disability Case 01-092

Case summary

A young boy [referred to as David throughout the case study] diagnosed with 'conductive disorder syndrome.' Good evidence of multi agency involvement in this complex case management.

The story begins with reports of a pleasant boy doing well at school. Mum has some relationship problems with her estranged husband affecting her ability to care for her children. The nurse reports that she looked ill and suggested that she sought help from her GP; she is reluctant to do as she feels he will only wish to prescribe antidepressants.

As the story progresses the boy begins to exhibit some very challenging behaviour particularly relating to setting fire to property, placing himself and others in extreme danger, and threats to kill someone: This is poignantly illustrated by one particular case note entry: Fascination with fire - obsession. No lighters or matches at home. Set fire to tent - stamping out fire. Has been helped by medication. Still threatens with bricks, hammers. Language foul - steals - has threatened to kill puppy. Behaviour deliberate - attention seeking. Encouraged by

brothers - lots of mixed messages. Attempts at re-integration with school for 18/12 (usually 6-8/52).
Language so foul, threats very frequent. Educated outside then brought in. Short attention span - gradually settled - can stay over whole session. Made distinct improvements. Disruptive - stamping, moving around. Extremely calculating. Steals keys - locks himself in car. Came in to school with lighter - when outside, under hut then started to light it. Has brought full ones in - especially last week. Offered it to police. Also caught with kitchen knife 'to stab somebody'. Level P5 below average. Very street-wise. Set fire to wheelie bin - stamped out by mother and brother. "Threatening children, lighters and knives…
David has nightmares about a man he calls Sam who comes out of the wardrobe at night. The appearance of 'Sam' in David's life coincides with him becoming fixated on his own anus poking faeces and exposing himself to his brother. The nurse explores whether these behaviours could be associated with sexual abuse but this emphatically rejected by David. The story concludes with much of the challenging behaviour abating and David once again settled and doing quite well at school.

Profile of Learning Disability Case 01-093

Case summary
He is a little boy [referred to has Roger throughout the case files] of six diagnosed with autism spectrum disorder who attends Special School.
Exhibits challenging behaviour, temper tantrums, bizarre behaviour, outburst described by the paediatrician as being almost psychotic at times. Mum is exhausted as the child's sleeping patterns are erratic, settling late and awake early. In sheer desperation she locked him in his room so she could get some respite; he trashed the room smashing the television etc. Has requested extra help from Social Services particularly respite care, someone to look after him while she does the shopping etc. denied as she is already at the maximum allowable two night per month.
Risperidone discontinued by the paediatrician because he felt the bizarre behaviour and outbursts were a side effect of his medication. Risperidone later reinstated to manage the child's behaviour. Vallergan was prescribed as a night time sedative but mum not compliant with medication prescription, giving doses of Vallergan during the day to calm his behaviour.
The story concludes with Roger's behaviour becoming more volatile and unmanageable resulting in the decision to prescribe a major tranquiliser: Roger is hyperactive, screaming with lots of spinning and attempting to pick up illusory objects. He is very demanding with lots of jumping and bouncing around, he is aggressive throwing things pulling at people's clothing and at their skin. He has held his hands round his neck. He has temper tantrums which is really a concentration of all these behaviours some two or three times a day. At home his behaviour is equally bad as it is at school and sometimes his mother says it can be worse. His sleep is interrupted and he if often woken throughout the night and sometimes will not go back to sleep. His appetite is abnormally large but he doesn't seem to be piling on the weight. It is clear to me that he needs an increase dose of a major tranquiliser and the one that we are giving him, Olanzapine, so far needs to be pushed towards a limit. I have therefore prescribed for him Olanzapine 5mg BD for one week increasing 5mg mane and 7.5mg nocté

for a further week and ending finally on Olanzapine 7.5mg BD. I shall see him in three of four week's time and write to you further.

Profile of Learning Disability Case 01-094

Case summary

The client [referred to as Rose in the case file] is an adolescent girl with some mild learning difficulties managing independent care.

The client was born with the genetic condition Noonan Syndrome. The characteristics of this syndrome include heart defects, facial features including drooping eyelids, large downward slanting eyes, widely spaced eyes, flat nasal bridge, short neck, low hairline, low set ears with frontal lobe rotation and short stature in correct proportion.

Due to her severe birth heart defects she had a heart transplant at nine months old. She currently attends the Cardiology Clinic at the General Infirmary every three months and the Cardiology Clinic at London, yearly. The transplant is currently working well. Apart from the side effects of some of the immunosuppressant medication she needs to take. She is closely monitored at the Renal Unit because the immunosuppressant medication she takes can cause renal problems. The client is hearing impaired in both ears and normally wears hearing aids.

She is now well into adolescence and is becoming quite aware of the differences between her facial features and those of her peers. Her grandparents, who she lives with, and the school are becoming increasingly concerned that she is showing signs of depression and low self esteem. She has made such statements as 'why does everyone have to be nasty to me', 'one day I will kill myself', 'what is the point in being alive'. In addition to these negative thoughts, she seems to be showing some of the physical symptoms of depression in that she is sleeping very poorly and goes through bouts of either eating or not eating. Currently she feels that she is too fat. Seen by the child psychiatrist who prescribes the anti-depressant Dothiepin to which she responds very well.

The story concludes with a visit to the plastic surgeon who offers Rose a choice between extensive facial reconstructive surgery or less invasive surgery to 'pin back her ears.' She initially rejects any of the surgery offered and is asked to think about what she wants and given a follow up appointment in three months.

Profile of Learning Disability Case 01-095

Case summary

Client with undefined learning difficulties and mental health problems

The client's health fluctuates. he lives alone and he suffers with regular colds and chests. he has problems with eczema on his legs and scalp and he will scratch and make it sore. he regularly visits his GP for his depot injection on a three-weekly basis. He did suffer from epilepsy, but has not had a seizure for a number of years. He is in receipt of the higher rate of mobility. He attends outpatient clinic on a six-monthly basis and his medication is administered by dosette box on a weekly basis by the GP's wife. and this appears to work well for him. He is only on anti-convulsants medication at this time.

The client is quite an able gentleman. He enjoys reading Shakespeare, poetry and local history. However, he is deemed extremely vulnerable in other areas particularly around mental health needs and requires a lot of support with daily living activities. He very rarely goes out apart from shopping independently or if he goes out with his support worker. Defining feature of his care relates to supportive care required to remain in the community.

Profile of Learning Disability Case 01-096

Case summary

Client [referred to Mary throughout the case notes] with moderate learning difficulties, depression and schizophrenia.

The story begins with reports of Mary taking five overdoses within the past week thought to be 'copy cat' of her boyfriend. Appears to be impressionable and dominated by her boyfriend. Lives relatively independently with support from community sister and medical input. Appears to have difficulty sustaining relationships and is in counselling for this. Episodes of 'drunkenness' resulting in falls and injuries requiring attendance at A&E department remorseful following such incidents.

A central theme is documentation around an alleged rape requiring multi agency input and police involvement. Evidence surrounding alleged rape not clear with Mary having difficulty constructing exactly what occurred and with concepts such as 'penetration' and 'ejaculation.' Removed to a place of safety and investigated by the police. Prone to tell anyone she meet about the alleged rape and the identity and location of the person who carried out the alleged rape. Appears not to be able to bring closure to the incident and it is not clear from the records what actions were taken by the police and prosecuting authorities.

The story concludes with Mary feeling low and tearful/emotional remembering her son whose birthday it is this week.

Profile of Learning Disability Case 01-097

Case summary

Client with moderate learning disability and a complex range of physical and mental health problems, which also have impact on his psychological health. He has the following diagnoses:

- Congenital blindness
- Liver cirrhosis - portal hypertension and ascites
- Known Wolff-Parkinson-White Syndrome
- Anti-thrombin III deficiency with a history of recurrent DVT
- Pancytopenia
- Previous varicele bleeds therefore not anticoagulant (varices)
- Diabetes Mellitus

These complex health problems necessitate the staff caring for him to have an understanding of his health problems and how they present, especially in emergency situations. The client

needs a care plan which reflects his on-going monitoring needs, what to do if there are concerns about his health and how to manage emergency situations. There also needs to be a smooth transition from current services, GP, Consultant Physician and hospital services.
A feature of his demeanour is non compliance with medications, treatment regimes, appointments with health care professionals etc. Known to abuse alcohol which accounts for many of his health problems and contributes to his non compliance.
The story concludes with him developing diabetes mellitus controlled initially with diet and medication but progressing to insulin replacement.

Profile of Learning Disability Case 01-098

Case summary

The story starts with a meeting between Paul's [the client is referred to has Paul throughout the case file] teacher and the psychiatrist. Paul started school two years ago, and his teacher states that Paul's behaviour started to deteriorate nine months ago in association with the court decision with regard to him and his sister, that they should be removed from the family and put in the care of Social Services. Since that decision there has been a steady decline, even though he has been quite happy with his foster carer for the last two years. There has been an increase in the intensity and frequency of his disturbed behaviour in school. The disturbed behaviour seems to be of an attention seeking type, where he makes demands by outbursts of behaviour. It does not seem to be a classic temper tantrum in that he carries out his disordered activities and looks to see if anyone is noticing. There is a considerable doubt as to what extent he is not in control of this behaviour. He has seen an Educational Psychologist recently, who thinks Paul is depressed and seriously disturbed.
The story recounts how Paul's relationship with his foster parents becomes strained and then breaks down because of his challenging behaviours. The decision is taken to move him from the foster home into a residential home.
Paul's behaviour improves while at the residential home becoming settled and exhibiting appropriate behaviour, nursing entry reports….met with children's home staff….staff report him as continuing to be settled. There have been no reported behavioural concerns. He is not going to bed inappropriately dressed, bed-wetting or stealing at the present time. School reports continued positive behaviour in school. Has been better behaved and more manageable on contact visits.

Profile of Learning Disability Case 01-099

Case summary

The client and his brother (12yrs) were abandoned by their birthmother. They now live with their half-sister. At present, Children and Families Team are putting a Section 37 report together, to recommend that she remains the guardian for himself and his brother. He is due to move to Special School, but no firm arrangements have been made as yet. His half-sister has three of her own children and requires support to recognise and understand his needs. He has behavioural problems linked to his LD. he has been living with his half-sister for five

months. Contact with his birth mother is supervised and structured by Social Services and occurs during holidays only.
He is displaying sexual behaviour towards little girls. Watching girls in the bath - sneakily. Nieces - 12yrs, 10 yrs, 4yrs. recently has pulled one onto his knee and made rocking movements. Was arrested by police age seven yrs for having sexual intercourse with a five old girl. Police dropped charges due to his lack of understanding of what he had done.
The client exhibits challenging behaviour at school very disruptive at times and absconding. Generally stable in the home environment but beginning to display similar challenging behaviours e.g. he 'trashed' his bedroom at one point.

Profile of Learning Disability Case 01-100

Case summary
Much of this case files relate to two parents who have borderline learning difficulties [mum assessed at IQ 72]. They have three children, two boys and one girl. The children have been removed from the parent's home because of parental abuse/neglect and placed with foster parents.
The parents are making a case through the courts that their children should be placed back in their care; up to the point of closure of this file they have been unsuccessful.
The recommendation from an independent organisation is that the middle and eldest child are placed back with the parents. Both of these children have been diagnosed as suffering from Autistic Spectrum Disorder and in the case of the girl she has some challenging behaviour including smearing herself and other children with her faeces.

Profile of Mental Health Case 00-100

Case summary
Crisis admission. Status on Admission: Informal.
Police were called when the patient became violent at home. He had used a piece of wood as a weapon. Family had become concerned due to his increased use of amphetamines over the past few weeks. Floridly psychotic on admission. Believes he is a quadruplet, has telepathic powers. Thinks he is a faith healer and has psychic abilities.

The patient claims that his elder brother threatened him with a knife which led to his violent outburst today. Believes his brother is having sex with under aged girls their activity is keeping him awake at night. He is generally in good physical health. A heavy smoker and user of illicit substances particularly Cannabis and Speed (amphetamines) which both tend to exacerbate his psychotic symptoms.
Has been living with his mother but family feel this is no longer appropriate due to his violence and aggression.
Remained an In-patient for seventy-one days with periods of home leave. Exhibited severe thought disorder, flight of ideas and auditory hallucinations. Treated with anti-psychotic medications including oral and IM depot injections.

Gradually improved over the course of his in-patient stay but continued to display quite grandiose delusions: “I am noble, I am royalty, I am an emperor” took to wearing a green headband at one stage to denote his royal heritage. Several instances of physical and verbal violent outbursts while on the ward. On one occasion, he carried out a vicious and serious assault on a patient.
The patient’s story concludes with extended periods of home leave care of his family. His behaviour remains bizarre at times and his auditory hallucinations endure; final nursing entry reads: “Patient’s step father informed us that patient made sexual comments towards his 13yr old daughter.”

Profile of Mental Health Case 00-101

Case summary
Acute admission via Ambulance. Status on Admission: Section 3 accompanied by S/W and two ambulance men.
This lady was admitted when the Police were called to attend as there was a disturbance in the street where the patient was being very abusive to neighbours.
Family state her mental health has deteriorated over last 2 weeks with her spending large amounts of money i.e. on a car, caravan, from a bank loan of £7,000. Apparently stopped taking her medication in two months ago as she was told she shouldn’t drive on medication.
The ladies mental state steadily improved following admission on medication, Lorazepam and Haloperidol. She remained stable on her medication but past history suggested that she would be non compliant with medication when discharged back into the community. The medical staff wanted to prescribe Risperidone depot injection as an alternative to oral medication ensuring compliance, she was initially reluctant to consent to this as she had heard ‘bad things’ about this treatment regime. However, she did finally consent to Risperidone depot injections. Unfortunately, she experienced severe and extremely debilitating side effects from the drug particularly severe akisthesia manifesting as not being able to sit still constantly pacing. The medical staff reported “Patient is low in mood, secondary to akisthesia. The prescription for Risperidone depot has appeared to decompensate her & cause unacceptable side effects.” Risperidone was withdrawn and Lorazepam and Haloperidol recommenced. Her akisthesia gradually subsided and she remained stable and pleasant.
The story concludes with the lady being allowed extended leave care of her family. Not long into the leave she stops taking her medication and becomes more and more agitated; final nursing report reads.. “Received a telephone call from patient’s daughter who explained leave did not go well. She said the patient had pulled her own house and her daughter’s house apart. She was playing music in the back garden very loud and all the neighbours have complained.
The lady has a high fasting blood sugar treated with Metformin 500 mg and diet and monitored by regular blood glucose measurements BM by the nursing staff.

Profile of Mental Health Case 00-102

Case summary
Type of admission crisis. Status informal.

Admitted via AE where see was seen exhibiting anxiety/panic symptoms. Admissions in the past with similar symptoms and presentation. Although she was not voicing any suicidal ideation or desire to self harm it was felt she was vulnerable and needed admitting at least overnight. She was deemed vulnerable as her mum, main carer, had been admitted to hospital suffering from carcinoma of the lung (mum subsequently died).
The medical diagnosis is classified as depersonalisation. The patient often voices feelings of 'not being here' and having the 'unreals.' This is captured in a nursing that reports: 'When speaking to patient she states she is at the bottom of a deep pit and feels she is about to lose her mind. She is unable to concentrate on anything.'
The notes pick the story up on day 164 of admission with the patient awaiting relocation to sheltered secure accommodation.
Her records portray her as a 'worrier' often tearful and anxious with occasional bouts of extreme agitation and distress requiring administration of Chlorpromazine. Between such bouts she sits in the lounge knitting. The nursing strategy is to use diversionary tactics, talking, walking, occupying etc. but the patient lacks any real motivation to participate preferring instead to dwell on her anxieties and feelings. When she does participate in occasional occupational therapy activities; the therapist describe her as emotionally labile with poor eye contact. They use STOP techniques and breathing exercises divert her attention away from her panic attacks and anxieties
The patient's story concludes with the patient being very anxious and low in mood not feeling that she can carry on much longer expressing thoughts of wanting to die to be with her mother.

Profile of Mental Health Case 00-103

Case summary
Admission Crisis. Informal Status:
Admitted to the psychiatric intensive care unit because of his deteriorating mental condition. Resident in a local mental health care rehabilitation unit immediately prior to this admission. Nursing Staff from the rehabilitation unit report a dramatic deterioration in the patient's mental state over last ten weeks leading up to this admission. He has increasingly become more agitated and restless, and has gone A.W.O.L. from the unit on several occasions. Staff also states that he has attempted to 'run away' on occasions by getting out through windows. The rehabilitation unit environment is no longer thought to be appropriate or capable of meeting his current mental health needs.
Medical entries query auditory and visual hallucinations however the patient refuses to elaborate upon this. Very agitated and restless on admission but unable to say why.

His agitation settled quite quickly on the unit treated with Haloperidol PRN and Clozaril. Periods of hyper salivation treated with Procyclidine and Hyocine. He regularly sought reassurance and company of the staff who reported his conversation has been 'short & disjointed with him apparently losing the trail of conversation regularly.'
He gradually improved over the period of his in patient hospital stay and presented no real management problems. The story concludes with him having longer periods of leave at the rehabilitation unit with a view to his ultimate discharge back to there.

Profile of Mental Health Case 00-104

Case summary
Diagnosis: Anxiety/Vertigo
On going for one year:
This lady was admitted as a psychiatric emergency (reason not apparent). Her mental ill health commenced following the death of her husband. Diagnosed anxiety/vertigo and prescribed selective serotonin re-uptake inhibitor; note contraindications. On admission she is given Amlodepine (also note contraindications).
During length of stay she is often reported to 'put herself on the floor', usually when requested to go for meals. On more than one occasion, she states that she has to fall before she can walk. The notes inform that there is no change in mental state over 12 month period, with comments ranging between 'interacting well, calm and quiet' to 'tearful, anxious and shouting'. This lady apparently often crawls back to the lounge from the dinning-room. On one occasion she takes her food to the lounge where it is taken from her. It is noted that she is willing to forego food rather than enter the dinning-room. Her risk assessment reports a normal diet.
There is an indication of a post-operative psychosis some 20 years earlier, but a clear psychiatric history is absent. She is also receiving medication for Parkinson's disease and pain.

Profile of Mental Health Case 00-105

Case summary
Crisis admission. Status on Admission: Section 2 MHA.
Patient admitted to the psychiatric intensive care unit because of his deteriorating mental health. Prior to his admission he was cared for in supported sheltered housing with input from the community mental health team. There have been concerns raised by the community team in the past weeks leading up to his admission as to his compliance with his Clozaril and during discussion with the patient he agreed that he had not taken this medication regularly since discharge. He also said that he felt the Clozaril was "useless" and "not helping". He was unkempt and neglected on admission with evidence of infestation with scabies.
The patient has a long history of schizophrenic type illness. He experiences both visual and auditory disturbances and says he is currently being "plagued" by auditory hallucinations.
The case notes pick up the story approximately seven months to his admission. He is reported as being pleasant and cooperative but still hearing voices on and off but. He says

the voices do not trouble him ‘one voice asking one other person to kill him’, one voice telling him very sorry.’
He remains in hospital on a section of the MHA [? Section 3]. The patient is concerned about his section, he feels that he has been in hospital for too long and should now be off section. At appeal the tribunal recommended that he remained compulsorily detained under the MHA until such time as suitable accommodation was available, but could be allowed section 17 leave care of his family.
Reports of boredom and heavy smoking are two recurring themes in the nursing notes. The patient is a very heavy smoker [self reports 60 – 80 cigarettes per day] as a consequence he has shortness of breath and is ‘chesty.’
The story concludes with the patient pleasant and cooperative and awaiting housing.

Profile of Mental Health Case 00-106

Case summary
Status on Admission Informal:
Admitted via a community based intensive support team. Complaining of paranoid ideas and auditory hallucinations for last 3 days. Auditory hallucinations in the form of male voice telling somebody to kill his friend. He also believed that people are attempting to harm him by putting chemical agents through the vents at his home. He also reports a poor sleep pattern.
The patient is a chain smoker smoking between eighty & one-hundred cigarettes per day which as probably caused his known emphysema.
The case notes pick up the story approximately one month into his admission [day thirty].
He has settled on to the unit and is reported to be pleasant with no management problems. He interacts well with fellow patients and staff spending most of his waking hours in the smoke room or the patio smoking his cigarettes. He believes that if he had accepted his medication he would have been a much better person and being able to get on with his life.
His delusions have been freed for many years and mainly negative around feeling threatened and being spied on by people in the street outside his house. He feels that poisonous gas was being poured through the vent. He takes these ‘threats’ seriously and sleeps with knife under his bed to protect himself from invaders.
He has home leave care of his brother or sister but these do not always go well. He stays on the settee all night fretful that people walking outside will once again put gas through the vents. He also believes that the television at his home is controlling him in some way but is reluctant to elaborate on this..
His auditory hallucinations and paranoia worsen during his hospital stay leading to an increase in his Risperidone. Final reports describe a man who is gradually isolating himself no longer interacting with staff or fellow patients as he used to.

Profile of Mental Health Case 00-107

Case summary
Crisis Admission. Status Section 2 of the Mental Health Act 1983.
Patient was admitted into the Psychiatric ICU having been assessed there.

Brought to Police Station following incident where the local chapel was defaced with graffiti?- unable to expand upon this due to a flight of ideas however is adamant that he did not deface chapel. The patient is a known diabetic controlled with Metformin and diet. Management of his diabetes poses a problem at the time of admission as he is fasting for 'religious reasons.'
The records report a patient who has very little insight into his mental health problems he believes that his main problem is his Diabetes Mellitus and insists that this is treated. Management of His Diabetes Mellitus is uncomplicated and causes no problems to him or the staff throughout his stay. He displays grandiose delusions believing that he is the Queens official correspondence. He is reported to have paranoid thoughts/beliefs in the nursing reports, 'Very suspicious / paranoid, limited interaction. Glazed expression. Kept whispering 'I'll sort it 'but the content and nature of his paranoia is not clear. He has a period of being very constipated which might be caused by his drug regime which known to cause constipation.
From the patient's perspective boredom defines is assessment of his in-patient stay thinks he has been in too long and needs to be discharged. The nursing and medical staff report that the patient is low in mood and gradually but noticeably isolating himself from others with very little spontaneous interaction. The reports of low mood changes to reports of depression as time progresses.
The story concludes with a depressed patient but one whose mood is lightening. He is taking periods of leave care of his family but not coping very well. His mother has recently had a stroke and not in a position to care for him on a full time basis. Occupational Therapy complete an assessment of his house and report a 'house in a considerable state of disrepair.'

Profile of Mental Health Case 01-076

Case summary
Crisis admission. Status on Admission: Informal.
35yrs male works in sales returned from holiday last Friday after relationship problems with his partner. Feeling, 'depressed', 'anxious'. 'I feel I am in a bad dream', can't eat-vomit. Losing weight, very poor sleep, poor memory & concentration anxious all the time. C/o sweating & shaking & palpitations, crying most of the time. Doesn't know what triggered off his depression. May be due to his relationship problems/stress at work. Has been thinking of jumping by his car from a bridge on the motorway. Had attempted suicide 3 yrs ago by trying to hang himself, was assessed at hospital but not admitted.
Settled down very quickly on to the ward his mood is assessed on day five subjectively as ' feels ups and downs' and objectively as looks brighter and happier then yesterday. By day eight the doctor reports that the patient looks depressed, fixed expression, poor eye contact & rapport, 'Just don't want to go one…can't see the point. Had spoken to his girlfriend yesterday who had told him that it might be difficult to continue their relationship, this he believes has precipitated the way he feels in himself to be low. Wants to kill himself by throwing himself in front of a bus or jumping off a building. I used to be scared of doing it before not anymore.
He remains suicidal, father thinks he's manipulative, and this is echoed by nursing staff in the weekly ward round meeting. The patient takes exception to this opinion nursing staff have of

him referring to being seen as manipulative. He added that he feels unable to ventilate his thoughts as he may be seen negatively.
He gradually improves and is euthymic playing his guitar and interacting well with staff and fellow patients.
The story concludes with the patient found sobbing when asked what was the matter he replied ' that he feels overwhelmed about his discharge and feels to have let himself down by the depths of his emotional feelings that he has experienced yesterday. He is trying to sort out college course and his social security and housing and feels stunned at every turn he has just telephoned social security and apparently he is not eligible for benefits because of his lack of contributions whilst he has been abroad very low in mood.'

Profile of Mental Health Case 01-077

Case summary
Crisis admission. Status on Admission: Informal.
25 year old female with psychotic symptoms e.g. paranoid ideation and hallucinations. Illicit use of amphetamines stopped taking them eight days ago; patient was accompanied by representative of the hostel she is staying at and a friend (resident at hostel).
Very suspicious and frightened, poor eye contact, very difficult to hold a rational conversation with her, writing in her diary through out the initial interview, expressed paranoid delusions. 'Cars follow me', 'people out there are trying to get me', 'Asian men and women', 'black man and big fat white woman'. Auditory hallucinations. 'I Hear them talking outside my room', 'lots of voices'. 'They talk to each other as well'. Visual hallucinations, 'I see them', 'taken a torch from my bag'. Her auditory hallucinations torment her and are predominated by the voice of 'Jack' a pimp who used to control her when she was a prostitute. She was sexually abused as a child, raped at eleven resulting in her delivering a son at twelve.
She believes she should be punished because, as she sees it men in her life have been sent to prison because of her; father went to prison for sexually abusing her, Jack [pimp] went to prison 1st husband went to prison (immoral earnings) and the Greek went to prison for raping her. She hurts herself to get back at her for all the hurt she caused them, as a minor she felt she needs punishing. She confided in her nurse that she feels bad about herself so vulnerable to exploitation dare not say no to people for fear of being beaten up she needs to punish herself.. She talked about the frequent repeated beating she received from various men. She talked about her exploitation sexually and the many times she'd been raped. She talked about the original rape and the difficulties of being a 12 yr old mother looking after a baby resembling the man who raped her. The child was taken into care and adopted at six weeks. She has repeated flashbacks of the various traumas she's has faced.
Suffers from Crohn's disease and chronic constipation that needed treatment in the general hospital on at least two occasions. She seems to distrust most men but appears to trust one of the doctors completely.
Her story concludes with her being ready for discharge but fearing this, stating that she thinks about taking her own life rather than face the outside world.

Profile of Mental Health Case 01-078

Case summary

Crisis admission. Status on Admission: Informal.

Patient is known to suffer from severe depression for many years. Has tried to take his own life on several occasions in the past. Known sufferer from Grand Mal epilepsy treated with medication Epilim monitored by the Neurologist.

His wife gave him an ultimatum that if he attempted suicide again she would leave him for good. He attempted suicide and she carried out her threat and walked out on him. She now wants to sell the matrimonial home to realise her share. Patient's father is concerned that his son will soon be homeless. Patient's response was to become more depressed threatening to end it all by committing suicide. Admitted for treatment of his depression and suicidal ideation. Gradually improved and has his mood lightened his thoughts turned from committing suicide to killing his wife first and then committing suicide. The Staff took his threat to kill his wife very seriously and informed her who in turn informed the police who interviewed him. Patient was seen by MHA commissioner, after his discussion patient appeared very angry stating 'I didn't think what I said to Dr. would be passed on to you lot… I want to kill my wife… I'll do it soon… take a knife and slash her throat from behind… & then I'll do the same to myself.

Several bouts of turning up drunk following leave and evidence of drinking on the ward 'empty vodka bottles under his pillow.' Intoxication and resultant maudlin behaviour appears to be a recurrent theme in the care records.

The story concludes with the patient ready for discharge with the advice to avoid intoxication through alcohol.

Profile of Mental Health Case 01-079

Case summary

Crisis admission. Status on Admission: Informal.

Mother entered a drop in GP medical centre & subsequently CPN was involved, Patient has recently moved to stay with mother with her child Son aged four. Mother has been concerned with her daughter's neglectful behaviour towards the child & her aggression towards the child. Also mother states Patient is hearing voices & believes something controls her behaviour/actions, Mood swings- charming one minute & aggressive the next, Concerns regarding violence acts towards baby -> an incident where she prevented patient from throwing baby across the room. The patient admits to aggression towards the child: "I hit him on Friday on his eye" "Just got mad and upset," } explains actions towards the child, 'I regret it so much". Reduced sleep "Haven't slept properly for a long time doing stupid things like staying up all time."

Admits to hearing voices in her head and expresses ideas of being controlled by some form of 'possession' but is quite guarded & gives tangential answers to specific questioning about this.

She makes steady progress throughout her in-patient stay with improving mental health. The core issue to be addressed is the continued care of the baby. The baby is currently staying with the patient's mum who herself has mental health problems and over the past weekend attempted to slash her wrists. Patient is concerned for the well-being of her child and is torn

between meeting her own needs for treatment and meeting the needs to care for her child. Social Services become involved in assessment of the child and the family's needs but their resources are overstretched resulting in long delays in assessment and support structures being put in place?
The story concludes with the patient being ready for discharge with no evidence of hearing voices and the medical staff querying postnatal psychosis or schizophrenia as the primary diagnosis. The baby is placed on the 'At Risk Register' and social services suggest placing the baby in care until housing has been sorted patient has told them that this is not what she wants. Social services are at present arranging a child protection case conference for the baby but as yet a date has not been set.

Profile of Mental Health Case 01-080

Case summary
Planned admission for alcohol detoxification
Says he drink too much' 'All right when I'm working, not working I get depressed.
Eye opener + uses alcohol first thing in the morning. Drinks in the house – not in pub
Drinks beer & strong larger (5 cans of strong larger) drinks till about 10pm.
Wants to get off the drink feels guilty feels it is affecting his relationship with his son and daughter. Managed on the ward through abstinence and Chlordiazepoxide medication. Very pleasant and amiable. No problems during detoxification other than a couple of episodes of epileptiform seizures; known epileptic on Valproate. The patient attributes his seizures to the large amount of coffee he is drinking; advised to limit his coffee intake.
Successfully completes detoxification and is discharged form hospital on day ten.

Profile of Mental Health Case 01-081

Case summary
Admission for Assessment. Status on Admission: Informal
Lady admitted for assessment of her mental state. Known to have suffered in the past from a bipolar affective disorder, alcohol abuse and cognitive impairment secondary to alcohol related brain damage. On admission she was non co-operative, sitting huddled with a blanket around her shoulders, with no eye contact. Her mood seemed agitated and labile, annoyed at everything that was happening to her and pre-occupied with her past. Her speech was soft but normal in rate. There were some flights of ideas. She believed she was having physical problems such as a stroke or epilepsy. Her cognition was normal but she had no insight into her condition.
Focus for her mental health problems appear to relate to the sheltered accommodation she currently resides at. Believes that the water supply is poisoned with lead and that 'they' are putting faeces in the water. She complains that the home is filthy and that there is a lot of prostitution and the staff are unqualified. She is adamant that she will not go back to live there.
Quickly settles on the ward. Has several occasions when she goes out and returns to the ward intoxicated usually attributes this to some emotional event in her life such as the anniversary of her sons death. Goes AWOL on at least two occasions.

Profile of Mental Health Case 01-082

Case summary

Crisis admission. Status on Admission: Section 3 Mental Health Act

This lady is well known to the psychiatric services, thirty previous admission for manic type symptoms in the past twelve years. Though to be non compliant with medication

Admitted via A&E where she had presented in a high and agitated mood could not remember why she rang the ambulance 'Can't remember why I rang for an ambulance'. 'I want to stop smoking'. Believes that she is pregnant 'I am pregnant husband told me' believes she is a doctor "I am GP and Psychiatrist." Pressure of speech and flight of ideas a key feature "Got plenty of ideas in my mind."

Disinhibited in the early part of her admission, refusing to wear underclothes, talking to fellow patients and staff in an inappropriate way about sexual matters and her periods. Prolactin levels noted to be high and thought to be side effect of her Risperidone medication. One episode of going AWOL from the ward and turning up in a pub, contacted on her mobile phone by the ward staff and returned without mishap.

Gradually improves with periods of leave being granted under section 17 of the Mental Health Act 1983. On one such leave she was returned to the ward by the police as she had become disruptive and aggressive at home. Appeal against compulsory detention under Section 3 of the MHA unsuccessful. Medical and nursing staff all believe that she is a danger to herself and that she will not comply with her medication regime voluntarily. Marked improvement in her mental state following increase in her Risperidone dose.

The story concludes with her being settled and stating that she wants to find a job. Remains on section 3 and states she has no intentions of appealing against this. The raised Prolactin levels are not resolved.

Profile of Mental Health Case 01-083

Case summary

Crisis admission. Status on Admission: Section 2 of the MHA.

Brought in by ambulance Paramedics from a neighbours house who contacted the hospital stating the patient had been behaving bizarrely, elated, scratching him self, scrabbling about on the floor, taking about Spirits and Ghosts. Was dressed only in Tracksuit bottoms and was loud and threatening in manner. Patients own flat is in a mess, yogurt on the floor, water thrown about to combat spirits. Diagnosed as Bi-polar affective disorder. Denies Auditory & visual hallucinations, but has stated that the Dr 'Glowed Green'.

Twenty-eight years past history of metal health, problems first episode when he was sixteen years old. Regular cannabis user since the age of thirteen; past four months been smoking cannabis heavily up to twenty pipes per day of 'skunk weed,' a very strong derivation of cannabis.

Many of his delusions refer to spirits and ghosts and persons travelling back in time from the fifteenth century to silence him as he knows the 'truth.' His beliefs appear to map to a series of ghost stories by an author he names and in particular 'Gino' a key player in these stories.

His early in-patient stay is defined by agitation and bizarre behaviour and hostility and aggression towards staff and fellow patients; affect flattens probably as a consequence of his medications. Gradually improves over time with less bizarre behaviour and improving mood. The story concludes with the patient settled and calm but frightened about being alone. Housing placement and self care issues are key problems needing to be addressed before discharge can be considered.

Profile of Mental Health Case 01-084

Case summary

Crisis admission. Status on Admission: Informal. Reviewed at request of Crisis Resolution team. Previous episode like this twenty years ago but not as bad as this time.

Partner out of prison for several weeks. Alcohol consumption increased. Recently drinking eight cans of lager / day + sherry. (Whilst at work, drinking less). Using as self - medication. Was drinking through the day. Withdrawal symptoms +. In addition uses cannabis 'one joint every night to knock her down for sleep.'

Exhibits some classical symptoms of depression and low mood. On going for past four years but deteriorated significantly in the past four months: concentration very poor, can't recall watching TV, losing track of time, poor, sleep pattern sleeping for only a couple of hours, wakes at 2am, no energy needs to push her self to carry out daily activities of living, poor appetite 'none at all,' not eating much. Feels hopeless, 'bleak', suicide doesn't scare her, no plans at moment but is worried about the potential to act on this.

Trigger for the recent deterioration in mood appears to be release of partner from prison following a three/half year sentence. Fell out six months ago does not know where he is believes that he is having an affair, sees that there was no evidence for this, decided to take OD.

Settles on to the ward quite quickly, describe by the nursing staff as tremulous, quite anxious, and pleasant on contact. Patient's mother worried at the marked weight loss down to 55Kg (8½ Stones) weekly weight measurements and supplementary drinks (Fortisip) implemented. Patient unwilling to drink the supplementary drinks, as she believes that they contain milk extracts, it is not clear (not investigated) why she feels she should not take foods containing milk extracts.

Mood improves steadily, often reported to be laughing and joking with fellow patients. Discharged care of mother and community team on day thirteen.

Profile of Mental Health Case 01-085

Case summary

Crisis admission. Status on Admission: Informal.

GP referred following low mood and a H/O self harm and stated suicidal intent. Weepy. Attempted and superficially cut over wrists two weeks ago, has had similar attempts in the past about six times in the past eighteen months.

Currently on police bail for assault due to appear in court six days from admission date. Mood lightens quickly following admission but mum requests that discharge is not considered prematurely for her daughter as she feels she may attempt to take her own life.
Attends court for her hearing and the case is adjourned for three months. Patient requests and is granted leave the day after her court appearance and actually discharged while on leave on day twenty one.

Profile of Mental Health Case 01-086

Case summary
Crisis admission. Status on Admission: Informal. Admitted following referral from A&E. Patient is well known to the psychiatric services diagnosed with Schizophrenia currently taking Clozapine and Procyclidine. Possible trigger for current mental state are concerns that she has regarding her mother's recent crisis of an eye condition and the patient feared her mother may go blind
Yesterday took an overdose of Clozapine (twenty-eight tablets of 100mg), sister found her and brought her to A&E after calling an ambulance, and she vomited after taking the overdose. On admission feels medically stable but says 'I'm feeling paranoid' believes people know what she is thinking (? thought broadcasting) and states "Feel like people can control me inside my head." Does experience auditory hallucination occasionally but not concerned too much about it "except when I am trying to sleep."
She says she took an overdose because she was generally fed up with life, she thinks she has improved with Clozapine but still remains paranoid and thinks that "life is not worth living," says family and friends don't understand her illness, lives alone.
Initially her mood improved and was stable although when questioned admits to thoughts of suicide and self-harm. Several episodes of deliberate self-harm during the admission usually involving superficial gauges and scratches to her wrists using a pen. Nursed in an outer seclusion room following one such attempt of deliberate self-harm, she set fire to her clothing requiring dousing using a fire extinguisher. Sustained burns to her chest that needed medical treatment. States that she set fire to herself because she was experiencing thoughts of suicide.
The story concludes with her mood significantly improved, improving, and looking forward to living in her new flat. Several periods of successful leave from the ward culminate in a plan for discharge.

Profile of Mental Health Case 01-087

Case summary
Crisis admission. Status on Admission: Informal. Active problems delusional Ideas, paranoid, minor Impairment in hearing.
Recent breakdown in her relationship with her husband. States that her husband bullied her and because of this she decided to leave and live on her own. Believes that her husband and sister are getting in to the house and stealing her jewellery.
Finds paper in the drive saying she is going off her trolley gets upset and tearful when people don't believe her. Accusing people of stealing things and family says she has misplaced

things. Believes that her telephone is bugged, neighbour wants her dead – as she's worth more dead. She's talking in riddles, wouldn't agree to move nearer family.
Treated with Risperidol, two weeks into admission noted to be pleasant, quite dramatic expressions and hand gestures almost comical. Speech – circumstantial, no delusions at present – 'I thought people were against me and things – I don't know any more, the medications have made the difference.' No hallucinations – no thoughts of self harm cognition intact. Insight good.
Takes long days out with her ex partner trips to the coast etc. Successful days out and home leave periods culminates in plans for discharge following home assessment and recommendation for discharge from the occupational therapist.

Profile of Mental Health Case 01-088

Case summary
Status on Admission: Informal.
Admitted for anxiety & for alcohol detoxification regime. Known patient of having alcoholic problems, having feeling low and had thought of self harming which he planned last week but resist harming himself as has many reasons to live. He denies drinking spirits and having too many drinks during the day, but admits he drinks during the day and has desire to drink all the day, he thinks he should stop drinking but can't resist.
Patient states he's been having problems with wife for 34yrs, states she's very argumentative, feels his wife never thinks he's good enough whatever he does. States they argue a lot until he eventually 'snaps' resulting in binge drinking. This happened recently and he has been drinking approx six cans of beer per day in order to 'block it out' Has suffered cold sweats passed out on one occasion and has 'wet himself.'
Describes feeling anxious, agitated and flat in mood, feels responsible about marriage not working out as planned, states he has considered leaving wife but is too financially 'tangled'. Describes no appetite for last three days, but sleep remains same i.e. no problem.
Uneventful detoxification with minimal problems. Makes a pact with his son not to drink alcohol anymore. Discharged on day eight.

Profile of Mental Health Case 01-089

Case summary
Crisis team referral, following urgent request for assessment by CPN.
Patient has been suffering from anxiety for last two weeks, His Olanzapine was increased from 5mg-10mg last week, Last two days he has been shivering constantly, Denies non compliance with medication. Some evidence of depression.
Doesn't know what is going to help him out of this. He didn't sleep well last night. His wife is concerned about his health. ?suicidal risk – patient is unwilling to discuss any details. Still attending psychodynamics/psychotherapy once a week. Repeatedly told us that he has been having catastrophic thoughts but unable to explain it. B-blocker was tried in the past with no effect. Tremulous, difficulty with speaking, stuttering and long pauses. He says that he would end up saying what he did not mean.

A key feature of his presentation is panic attacks and feelings that some catastrophic event is about to happen. Extremely anxious & restless, severe flapping shakes of clenched hands clutched to his sides and bend at the elbow. Gets more and more worked up worried about not having his job, fulfilling his obligations, worried about being alone when his wife goes to work, worried about being financially dependable. Catastrophic thoughts – youngest step son may never come back from his holiday overseas. Wishing to fade away. No active suicidal thoughts -says he is in hell trapped by his worries nothing seems to help.
Had four Electroplexy (ECT) treatments, scheduled for six but did not feel they were helping. Makes little progress on his anxieties during is hospital stay. Mother wants him to be transferred to a well-known specialist private mental health unit for intensive treatment; patient is unwilling to do this but feels dominated by his mother.
One episode of threatening to kill his wife whilst on home leave, patient escorted back to the ward by police. Trying to put his hands around people's throats wanting to kill everyone
Referred for MRI scan to exclude any pathological changes in his brain and spine that may explain is tremulous movements, MRI no abnormality detected.
The story concludes with very little evidence of improvement or change in his overall mental health status and the patient requesting discharge with some structured home activities.

Profile of Mental Health Case 01-090

Case summary
Status on Admission: Informal.
Admitted because she complains of feeling low and depressed for the past 5-6 weeks, known case of MDP on lithium from 1991, on Cipramil for the past 2 years, Sleep disturbed, wakes up in the night, I get depressed for nothing I have good husband, good friends, good house' 'I don't have energy to do anything sometimes I watch TV.
Started with depression at the age of fourteen years, prescribed medications, which she didn't take regularly, had another episode at the age of twenty-one years. Diagnosed with when she was 24 she was diagnosed as Manic Depressive Psychosis (MDP) and started on Lithium.
One attempt at suicide three years back, took around 30-40 tablets, She doesn't remember the name of the tablets.
Settled quickly on the ward with improvements in both appetite and sleeping patterns, although she complained that she was sleeping excessively. Appeared to appreciate the sanctuary of the ward referring to it as a 'acting like a safety net.'
The story concludes with her discharge care of her family and being advised to build a structure in her life, motivation etc rather than change in pharmacological regime. Citalopram was increased to 60mg daily. Has some misgivings about her discharge and the risks this poses, though these are not elaborated on.

Profile of Paediatric Case 00-011

Case summary
Age: 8/12 Gender: Male
Diagnosis: Purpuric rash vomiting – treat as meningococcal infection

Length of stay: 6 days
GENERAL SUMMARY OF CASE:-
Admitted via A/E with a history of vomiting for 6 hrs and purpuric rash on right leg. Rash spreading. (Has been in contact with his cousin who is at present in hospital with meningococcal infection).
Treatment given was IV antibiotics, referral to public health.
Discharged following a good response to IV antibiotics. Outpatient's appointment and hearing test arranged on discharge

Profile of Paediatric Case 00-064

Case summary
Age: 20/12
Gender: Female
Diagnosis: Croup
Length of stay: 9 hrs
Admitted following history of coughing overnight and febrile.
Previous admissions: Croup aged 1 yr; Vomiting age 18/12.
Born at 30wks gestation – caesarean section for pre-eclampsia. Whilst on the ward queried to have had a febrile convulsion, temperature 39°C. Anti pyretic treatment given.
Discharged home within the evening due to being apyrexial for 7 hrs. 24hrs open access to the ward permitted.

Profile of Paediatric Case 00-068

Case summary
Age: 6/52
Gender: Female
Diagnosis: Purpuric rash
Length of stay: 4 days
6/52 old baby girl admitted with non-blanching rash, otherwise well.
Commenced antibiotics IV until all results obtained. IV antibiotics given for 48 hrs. Heart murmur noted on physical examination. To be re-assessed in clinic 6/52 following discharge.
Rash subsided and discharged home 4 days following admission.

Profile of Paediatric Case 00-069

Case summary
Age: 2 Years old
Gender: Male
Diagnosis: Asthmatic attack
Length of stay: 2 days

General Summary of Case:
Two year old boy admitted with wheeze – known asthmatic who normally requires Ventolin daily. Mother has not given Ventolin due to having none available.
Admitted for regular Ventolin, chest x-ray and observation.
Condition improved and discharged home with Ventolin and an out-patient appointment.

Profile of Paediatric Case 00-070

Case summary
Age: 5 years old
Gender: Boy
Diagnosis: Epileptic Convulsion
Length of stay: 1 day
General Summary of Case:
Admitted following status epilepticus (40 mins). He is a child who is known to have epilepsy. He has hydrocephalus with a ventricular peritoneal shunt in-situ. Fits are normally right sided only. He was given diazepam PR in ambulance. Post-ictal on arrival to hospital.
No focus for fit established. VP shunt working well. Medication – Epilim (anti-convulsants) reviewed and dosage changed.
Discharged home following 24 hours admission.

Profile of Paediatric Case 00-071

Case summary
Age: 4 years old
Gender: Male
Diagnosis: Unexplained purpuric rash. ? Meningococcal infection – treat as such
Length of Stay: 6 days
General Summary of Case:
4 year old boy admitted with an unexplained purpuric rash. The child was generally well, afebrile but rash extending. Decision was made to treat as a meningococcal infection. Antibiotics given for a period of 5 days. Public Health informed. Discharged home on Day 6. No previous medical history. All immunisations up to date.

Profile of Paediatric Case 00-072

Case summary
Age: 10 years old
Gender: Female
Diagnosis: Abdo pain
Length of stay: Two episodes of care: Day 1 - Day 2, 1 day.
Re-admitted Day 4 – Day 5, 1 day.
General Summary of Case:

First episode of care – fell off a horse and sustained injury to left flank. Complaining of abdo pain and vomiting. Ultrasound performed – normal. Urine blood +++ protein ++. Discharged following 24 hrs of care.
Second episode of care – re-admitted after continuing to vomit – dehydrated on admission – commenced intravenous fluids – repeat renal scan normal treated with analgesia. Urine specimen sent. All results were negative – discharged home – seen in clinic following day – looked well – no further vomiting.

Profile of Paediatric Case 00-074

Case summary
Age: 6 years old
Gender: Female
Diagnosis: Encephalitis? Epilepsy
Length of stay: 11 days
General Summary of Case:
Six year old girl admitted following generalised fitting movements. She required treatment for the seizure - Diazepam; Lorazepam; Paraldehyde and Phenytoin. She was intubated and ventilated for 24hrs.
Showing raised WCC – commenced on Cefotaxime and Aciclovir. CT scan was normal.
Previously fit and well prior to admission – mother has epilepsy, well controlled.
Discharged home following 11 days of treatment. Out-patients appointment given on discharge.

Profile of Paediatric Case 00-076

Case summary
Age: 2½ years old
Gender: Male
Diagnosis: Viral upper respiratory tract infection – leading to febrile convulsion.
Length of stay: 1 day
General Summary of Case:
2½ year old boy admitted via A&E following 2 febrile convulsions. Associated pyrexia.
24hr history of being ‘snuffly’ – not eating on day of admission.
No previous admissions, but previously anaemic. Awaiting surgery for hypospadias. On admission - pyrexia, throat red, tonsils enlarged. Small blanching pin-point spots on right calf.
Discharged 24hrs following admission. Medication on discharge Paracetamol, Brufen and Difflam. Parents given advice and written information regarding febrile convulsions.

Profile of Paediatric Case 00-078

Case summary
Age: 6 years old
Gender: Female
Diagnosis: Fractured radius and ulna
Length of stay: 5 days
General Summary of Case:
6 year old girl admitted via A&E following a fall from a bench.
On admittance complaining of pain in right forearm. Diagnosis – fractured radius and ulna.
Prepared for theatre – underwent a general anaesthetic for manipulation of fracture.
Discharged home – follow-up arranged.

Profile of Paediatric Case 00-084

Case summary
Age: 9 years
Gender: Male
Diagnosis: Acute exacerbation of asthma? Aspiration
Length of stay: 2 days
General Summary of Case:
Nine year old boy admitted with acute exacerbation of asthma. ? Aspiration.
Previous history – diagnosed with cerebral palsy at the age of 8/12. Frequent hospital admissions due to chest infections.
This episode of care was for 2 days in length. Wheezy on admission requiring Salbutamol hourly. Commenced Prednisolone. O2 to keep saturations above 92%.
No temperature. Chest x-ray - bilateral wheeze – commenced antibiotics.
Discharged home with Salbutamol via spacer, antibiotics and follow up appointment.

Profile of Paediatric Case 00-085

Case summary
Age: 8 yrs
Gender: Male
Diagnosis: Grade 3 supracondylar Fracture (L) humerus
Length of stay: 1 day [plus readmission x 1 day]
General Summary of Case:-
Eight year old boy admitted at 21:10 hours with a painful left elbow.
No past medical history
O/A (L) elbow was swollen and bruised. He had a good radial pulse and there was no sensory loss.
He went to theatre where he had manipulation and k wiring. A backslab was placed in situ and he was discharged the following day with a weeks follow up appointment.

Profile of Paediatric Case 00-086

Case summary
Age: 16/12
Gender: Male
Diagnosis: Viral induced wheeze
Length of stay: 5 days
General Summary of Case:-
16/12 old boy admitted with a viral induced wheeze.
No previous hospital admissions.
Born at 34 weeks SCBU for 2 weeks – no specific problems identified.
This episode of care was 5 days in length. Drinking well but not eating. Wheezing – required intermittent O2 when O2 sats dropped below 94%? Sleep apnoea
Responded well to Prednisolone, Ventolin and a course of antibiotics.
Discharged home with PRN Ventolin and an outpatient's appointment.

Profile of Paediatric Case 00-087

Case summary
Admitted via A&E following a fall at home down some concrete steps.
No history of loss of consciousness or vomiting. Skull X-demonstrated a fracture in the occipital area. Child also had a right haemotympanium and # right temporal bone. Known to have grommets fitted and referred to ENT for an opinion and advise on continued management.
Four hourly neurological observations were unremarkable and remained stable throughout his four day in-patient stay. Discharged home on day four with Augmentin 250mg TDS for a further seven days.
Unfortunately the multidisciplinary notes scanned so badly they were largely undecipherable as we could not verify there accuracy they were rejected.

Profile of Paediatric Case 01-072

Case summary
Age: 10 years old
Gender: Female
Diagnosis: Abdo pain
Length of stay: Two episodes of care: Day 1 - Day 2, 1 day.
Re-admitted Day 4 – Day 5, 1 day.
General Summary of Case:

First episode of care – fell off a horse and sustained injury to left flank. Complaining of abdo pain and vomiting. Ultrasound performed – normal. Urine blood +++ protein ++. Discharged following 24 hrs of care.
Second episode of care – re-admitted after continuing to vomit – dehydrated on admission – commenced intravenous fluids – repeat renal scan normal treated with analgesia. Urine specimen sent. All results were negative – discharged home – seen in clinic following day – looked well – no further vomiting.